State of Tennessee
Health Services and Development Agency
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Date: **October 9, 2015**

To: **HSDA Members**

From: **Melanie M. Hill, Executive Director**

Re: **CONSENT CALENDAR JUSTIFICATION**
CN1508-030 – The Endoscopy Center

As permitted by Statute and further explained by Agency Rule on the last page of this memo, I have placed this application on the Consent Calendar based upon my determination that the application appears to meet the established criteria for granting a certificate of need. If Agency Members determine that the criteria have been met, a member may move to approve the application by adopting the criteria set forth in this justification or develop another motion for approval that addresses each of the three criteria required for approval of a certificate of need. If you find one or more of the criteria have not been met, then a motion to deny is in order.

At the time the application entered the September 1, 2015 review cycle, it was not opposed. If the application is opposed prior to being heard, it will move to the bottom of the regular October agenda and the applicant will make a full presentation.

Summary—

The Endoscopy Center is seeking approval to relocate approximately 1.4 miles from its current site where it has operated for the past 29 years.

The Endoscopy Center is a single specialty ambulatory surgical treatment center owned by The Endoscopy Center of Knoxville, L.P. The general partner is AmSurg KEC, Inc. with 51% ownership and the limited partner is The Endoscopy Center with a 49% ownership, which is a Tennessee general partnership composed of nine gastroenterologists in the physician practice Gastrointestinal Associates, who each own 11.111% of the facility. There are three other physicians who will utilize the facility who are not owners of the facility.

The new facility will be open from 7 A.M. to 4 P. M. five days a week. The new layout will provide a more efficient work space. The current building no longer meets current endoscopy standards. Two new physicians have committed to the practice and will bring 3100 new cases in CY2017. The physician practice will also relocate to the new building.

The facility participates in Medicare and TennCare with the payor mix being 60%/1% respectively. It is currently contracted with three TennCare MCOs in the service area and is currently in contract negotiations with a fourth TennCare MCO.

Executive Director Justification -

I recommend approval of certificate of need application CN1508-030 to relocate The Endoscopy Center, an existing, single specialty ASTC, approximately 1.4 miles from its current 29-year site at 801 Weisgarber Road, Suite 100, to a currently unaddressed site in the northwest quadrant of the intersection of Middlebrook Pike and Dowell Springs Boulevard in Knoxville based upon my belief the following general criteria for a certificate of need have been met.

Need- The need to relocate and replace the 29-year ambulatory surgical treatment center is well established. The physical space will expand from 3,686 SF to 16,732 SF. The new design will provide a more functional and efficient work space. The 1.4 mile distance from the existing site will continue to serve the health needs of the existing patient base.

Economic Feasibility- While the total project cost is $13,791,719, that amount includes the facility lease payments for 15 years. The actual capital cost of $6.9 million is being funded through a loan from the applicant's general partner, AmSurg KEC, Inc. The facility reported a positive operating margin in 2014 and continued positive margins are anticipated at the new location with the longer operating hours and increased utilization.

Contribution to the Orderly Development of Health Care-The project does contribute to the orderly development of health care because the new location will provide more suitable space and permit it to expand its service hours. The applicant is contracted with three of four TennCare MCOs in the service area and has a contract under review with the fourth.

Statutory Citation -TCA 68-11-1608. Review of applications -- Report

(d) The executive director may establish a date of less than sixty (60) days for reports on applications that are to be considered for a consent or emergency calendar established in accordance with agency rule. Any such rule shall provide that, in order to qualify for the consent calendar, an application must not be opposed by any person with legal standing to oppose and the application must appear to meet the established criteria for the issuance of a certificate of need. If opposition is stated in writing prior to the application being formally considered by the agency, it shall be taken off the consent calendar and placed on the next regular agenda, unless waived by the parties.

Rules of the Health Services and Development Agency - 0720-10-.05 CONSENT CALENDAR

(1) Each monthly meeting's agenda will be available for both a consent calendar and a regular calendar.

(2) In order to be placed on the consent calendar, the application must not be opposed by anyone having legal standing to oppose the application, and the executive director must determine that the application appears to meet the established criteria for granting a certificate of need. Public notice of all applications intended to be placed on the consent calendar will be given.

(3) As to all applications which are placed on the consent calendar, the reviewing agency shall file its official report with The Agency within thirty (30) days of the beginning of the applicable review cycle.

(4) If opposition by anyone having legal standing to oppose the application is stated in writing prior to the application being formally considered by The Agency, it will be taken off the consent calendar and placed on the next regular agenda. Any member of The Agency may state opposition to the application being heard on the consent calendar, and if reasonable grounds for such opposition are given, the application will be removed from the consent calendar and placed on the next regular agenda.

(a) For purposes of this rule, the "next regular agenda" means the next regular calendar to be considered at the same monthly meeting.

(5) Any application which remains on the consent calendar will be individually considered and voted upon by The Agency.

HEALTH SERVICES AND DEVELOPMENT AGENCY MEETING
OCTOBER 28, 2015
APPLICATION SUMMARY

NAME OF PROJECT:	The Endoscopy Center
PROJECT NUMBER:	CN1508-030
ADDRESS:	Unaddressed Site Near the intersection of Middlebrook Pike and Dowell Springs Boulevard Knoxville (Knox County), Tennessee 37909
LEGAL OWNER:	The Endoscopy Center of Knoxville, L.P. c/o AmSurg Corp 1A Burton Hills Boulevard Nashville (Davidson County), Tennessee 37215
OPERATING ENTITY:	AmSurg Corp 1A Burton Hills Boulevard Nashville, Tennessee 37215
CONTACT PERSON:	John Wellborn (615) 665-2002
DATE FILED:	June 14, 2015
PROJECT COST:	$13,791,719
FINANCING:	Commercial Loan
PURPOSE OF REVIEW:	The relocation of an existing single specialty ambulatory surgical treatment center (ASTC) at a construction cost in excess of $2 million.

DESCRIPTION:

The Endoscopy Center (TEC), licensed since October 1986, is seeking approval to relocate its existing 3,686 square foot (SF) single specialty ambulatory surgical treatment center (ASTC) limited to endoscopy surgical cases from 801 Weisgarber Road in Knoxville (Knox County), Tennessee, to a 16,732 SF facility located on the 2nd floor of a new building to be constructed on a 4.5 acre unaddressed site near the intersection of Middlebrook Pike and Dowell Springs Boulevard in Knoxville, a distance of approximately 1.4 miles. The ASTC will

have its own dedicated space on the 2nd floor of the new building that will be completely separate from the physician offices of Gastroenterology Associates (GIA) on the 1st and 2nd floor of the building. As part of the design, TEC plans to decrease its procedure room complement from 8 to 6 rooms, expand pre-op and post-op recovery stations from 7 to 18 stations, and provide its own patient/family waiting areas, clinical and administrative support space. The applicant expects to renovate and equip the new facility at a construction cost of approximately $4,300,124 ($257/SF) or approximately 31.2% of the total cost of the project. This application has been placed under **CONSENT CALENDAR REVIEW** in accordance with TCA §68-11-1608(d) and Agency Rule 0720-10-.05.

SERVICE SPECIFIC CRITERIA AND STANDARD REVIEW

CONSTRUCTION, RENOVATION, EXPANSION, AND REPLACEMENT OF HEALTH CARE INSTITUTIONS

2. For relocation or replacement of an existing licensed health care institution:

    a. The applicant should provide plans which include costs for both renovation and relocation, demonstrating the strengths and weaknesses of each alternative.

As approved in 89-CN-178, the existing facility at 801 Weisgarber Road in Knoxville has historically included shared space with the GIA medical group such as patient/family waiting areas and a shared reception area. However, this arrangement changed in 2012. As addressed on pages 13 – 15 of the application and Item 3.c of the 8/25/15 supplemental response, changes in Medicare requirements under 42CFR416.44(a)(2) resulted in action taken by TDH as part of an annual recertification survey on April 3-4, 2012 to enforce the Medicare separation requirement, where ASTCs could not share space with adjoining medical practices. Following on-site revisits on May 3 and June 21, 2012, TDH accepted the applicant's survey plan of correction to change the ASTC and medical practice's schedules to mutually exclusive half days, Monday–Friday, effective May 2012. ***(Please note: A copy of the July 9, 2012 acceptance letter is provided with the survey attachments in the application. TEC provided clarification in Item 3.c of the 8/25/15 supplemental response and a letter submitted as additional information to Supplemental 1 on 8/28/15).***

The applicant has evaluated the alternatives and determined there is no remaining leasable space in the existing building to provide separate facilities for each party. The proposed facility provides several benefits, including, but not limited to, proximity to the existing ASTC, ease of interstate access (I-40 and I-75 corridors), high visibility, and a location that has a growing community of health care providers, including the Tennova Physicians Regional Medical Center that will be relocating to the area as approved in Metro Knoxville HMA d/b/a Tennova Healthcare Physicians Regional Medical Center, CN1408-034A.

It appears that the applicant meets this criterion.

b. The applicant should demonstrate that there is an acceptable existing or projected future demand for the proposed project.

The applicant identified a 15% decline in endoscopy surgical cases from 2013-2015 as a result of several factors including the limited half day surgical schedule and the recent death of 1 of TEC's medical staff physicians who performed approximately 1,500 cases per year at the facility. The applicant expects utilization to increase from approximately 9,560 cases in CY2015 to 9,752 cases in CY 2017 through normal growth in physician referrals (average of 1,219 cases per room or approximately 65% of the 1,867 optimal ASTC procedure room standard).

If the proposed relocation is approved, the ASTC's return to full day normal hours of operation will facilitate the addition of approximately 3,100 endoscopy cases by 2 physicians who do not have room or sufficient time to perform their cases at the existing facility. Accordingly, the applicant projects a caseload of 12,852 cases in Year 1 of the project for an average of 2,142 cases/room or 115% of the optimal standard. The applicant has provided an 8/11/15 signed letter of intent in the original application from the 2 new prospective physicians (Drs. Moore and Gilbert) that identifies their willingness to perform a combined total of approximately 3,100 endoscopy cases at the new facility in CY2017 (Year 1).

It appears that the application meets this criterion.

STAFF SUMMARY

Note to Agency members: This staff summary is a synopsis of the original application and supplemental responses submitted by the applicant. Any HSDA Staff comments will be presented as a "Note to Agency members" in bold italic.

The applicant, The Endoscopy Center (TEC), seeks Certificate of Need approval to relocate its existing single specialty ASTC from 801 Weisgarber Road in Knoxville (Knox County), Tennessee to leased space on the second floor of a new 3-story building to be constructed on an unaddressed 4.5 acre site near the intersection of Middlebrook Pike and Dowell Springs Boulevard in Knoxville, a distance of approximately 1.4 miles. As part of the project, the applicant will occupy approximately 16,732 useable square feet (SF) of space on the second floor of the new building that meets Medicare space separation requirements between an ASTC and a physician practice allowing it to return to a normal full day operating schedule (Note: Floors 1 and 2 will be reserved for use by physicians belonging to Gastroenterology Associates). The design of the ASTC includes the following:

1. A decrease from 8 to 6 procedure rooms,
2. An increase from 7 to 18 pre-op and post-op recovery stations,
3. Separate areas for patient and family waiting, clinical and administrative support areas.
4. For privacy purposes, the design also includes patient exits and a separate ambulance entry that are not visible from the waiting rooms.
5. The cost for the build-out of the facility is approximately $4,300,124 ($257/SF) and will be funded through a 10-year loan to the applicant LLC provided by AmSurg Corp, the 51% majority owner of the LLC and the manager of the facility.

History

The Endoscopy Center (TEC) has operated as a licensed single specialty ASTC limited to endoscopy surgical cases since 1986. The original facility with 8 procedure rooms was located at 1112 Weisgarber Road in Knoxville but later relocated to its current site at 801 Weisgarber Road in Knoxville as approved in 89-CN-178 at a cost of $683,600.00. The applicant states that TEC was the highest of 7 ASTC's performing outpatient endoscopy cases in the primary service area until through the fiscal year ending June 2013. As an example, review of Table 8-A on page 39 of the application shows that TEC accounted for 31,162 or 39.9% of 78,179 total GI endoscopy cases from FY2012-FY2014 for an average of 10,387 cases per year during the period (average of 1,300 cases per procedure room).

During an annual recertification survey by the Tennessee Department of Health (TDH) in April 2012, the facility was found to be in violation of basic Medicare program requirements under 42 CFR416.44(a)(2) recently implemented by the Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Resources, requiring separate waiting and recovery areas in lieu of space-sharing arrangements between ASTCs and adjoining physician practice offices, such as the arrangement the facility had historically observed with GIA over the years. The problem was corrected beginning May 2012 upon TDH's acceptance of the provider's plan of correction stating that the applicant would have exclusive use of the premises for its ASTC from 7AM to noon, daily and GIA would have exclusive use for its medical group practice in the afternoons. ***Note: For further information about this development, please see pages 13-15-R and 41-42 of the application, a copy of the April 2012 recertification survey and TDH acceptance letter in the attachments, and related clarification provided in the August 25, 2015 supplemental response.***

As a result of the half-day surgery schedule and the recent death of one of the applicant's medical staff physicians, the ASTC's utilization has decreased by approximately 15% from 11,251 cases in calendar year CY2013 to 9,560 cases in CY2015. However, the applicant estimates that utilization can increase to approximately 12,852 cases in Year 1 (CY2017) at the proposed new facility through the transfer of approximately 3,100 endoscopy surgical cases that have been performed at other hospitals and ASTCs in the service area by 2 of the applicant's 12 medical staff physicians due to the ASTC's restricted operating hours. A copy of an 8/11/2015 Letter of Intent signed by the 2 physicians is provided in the original application that attests to their willingness to transfer the 3,100 endoscopy cases to the TEC's proposed new location, subject to Certificate of Need approval of the project. Further, all of the applicant's 12 medical staff physicians intend to use space on the 3rd floor of the proposed new building as their primary practice office site. A list of the physicians was provided in response to Item 3.b of Supplemental 1.

Owner and Manager of the Facility

The ASTC is owned by The Endoscopy Center of Knoxville, L.P., a Tennessee Limited Partnership Corporation formed in November 1992. AmSurg KEC. Inc., a wholly owned subsidiary of AmSurg Corp (AmSurg), is the general partner and The Endoscopy Center is the limited partner. The limited partner consists of nine owners, who are physicians of the medical practice Gastroenterology Associates (GIA). AmSurg is based in Nashville, Tennessee and has served as manager of the facility since 1992. Prior to 1992 The Endoscopy Center was owned by GIA.

Highlights of the ownership and management structure of TEC are noted below.

- AmSurg and The Endoscopy Center hold 51% and 49% ownership interests, respectively, in the LP.
- Nine of the 12 medical staff physicians currently hold ownership interests in the limited partner entity.
- AmSurg is a Delaware corporation formed in 1995 and has centers in 23 states across the nation.
- A list of AmSurg's 12 Tennessee centers is provided in Supplemental 1.
- The management contract of the facility was amended in September 2004 to provide for renewals of the agreement through November 2016.

Facility Information

- The developer will construct a 3-story building on a 4.5 acre site at the address specified in the application. The building will house the ASTC on the 2nd floor and the physician offices of Gastroenterology Associates on the 1st and 3rd floors.
- Build-out & furnishings of 16,732 useable square feet for use by the new proposed ASTC are responsibility of applicant
- The ASTC will contain 6 procedure rooms, 6 pre-op stations, 12 post-op recovery stations, 1 nursing station, 1 nursing workroom, 1 anesthesia office, patient reception/waiting, patient consultation rooms, and other clinical and staff support areas.
- A floor plan drawing is included on page 8 and Attachment B.IV. in the application.
- There is no major medical equipment involved with this project. The applicant will transfer existing or purchase new minor medical equipment as necessary such as OR scopes and washers. The estimated cost of same is approximately $1,618,987.00.

Need

The applicant is basing the need for the proposed relocation and expansion of its existing, licensed ASTC on the following:

- ASTC's location on entire 2nd floor will be completely separate from GIA areas on other floors of the building and will comply with Medicare separation requirements for patient reception, waiting and recovery areas as discussed in the application and in further detail in Item 3.c of Supplemental 1.
- New location provides applicant ASTC the means to return to full day surgery schedule allowing applicant's medical staff physicians the ability to transfer approximately 3,100 endoscopy cases being performed at other hospitals & ASTCs due to the existing facility's restricted half-day schedule.

- New building allows GIA to provide clinic, office & support areas for all of its members.
- New building with state of the art features for ASTC and GIA.
- Existing 29-year old facility has no additional leasable space for expansion.

Service Area Demographics

The applicant's declared primary service area (PSA) consists of Anderson, Blount, Hamblen, Jefferson, Knox, and Sevier Counties. Residents of 6-county PSA accounted for approximately 82% of TEC's total patients in calendar year CY2014.

- The total population of the service area is estimated at 881,082 residents in calendar year CY2015 increasing by approximately 4.6% to 921,813 residents in CY2019.
- The overall statewide population is projected to increase by 3.7% from 2015 -2019.
- The total age 50+ age population, the age cohort most associated with endoscopy procedures, is estimated at 332,365 residents in CY2015 or approximately 38% of the total 6-county population compared to 35% statewide.
- The 50+ age population of Tennessee is expected to increase by approximately 8.6% from CY2015-CY2019.
- The latest 2015 percentage of the proposed service area population enrolled in the TennCare program is approximately 17.8%, compared to 21% statewide.
- Based on information the applicant provided from the Centers for Disease Control and TDH, the incidence rate of colon cancer in the PSA and Tennessee ranges from 40.1-42.6 per 100,000 population and 16.5-19.9 per 100,000 population for deaths from colon cancer. The applicant states that Tennessee is 1 of 12 states in the highest quartile for deaths from colon cancer.

Sources: Population Projection Data Files, Reassembled by the Tennessee Department of Health, Division of Policy, Planning and Assessment, Office of Health Statistics. Colon Cancer incidence & death rates – CDC and TDH data (see table on page 18 of application).

Service Area Historical Utilization

According to the Health Care Licensed Facilities Report maintained by TDH, there are 18 licensed ASTCs in the applicant's 6-county primary service area (PSA). Of the 18 licensed ASTCs, 7 reported performing endoscopy cases in the 2014 Joint Annual Report. The table below reflects the utilization trends of the 7 ASTCs performing endoscopy surgical cases in the PSA.

Service Area Utilization of ASTCs Performing Endoscopies in PSA, FY 2012-2014*

Name	# OR 2014	# PR 2014	Total Cases 2012	Total Cases 2013	Total Cases 2014	% Change Total Cases 12-14	Endo Cases 2014	Endo as % of Total Cases 2014
Children's West Surg Ctr	3	0	3,900	4,125	4,569	1.7%	184	4.0%
Ft Sanders West Surg Ctr	4	0	1,616	3,523	2,003	23.9%	137	6.8%
Parkwest Surg Ctr	5	1	4,681	4,775	5,343	14.1%	0	0.0%
TEC (applicant)	0	8	9,421	11,788	9,953	5.5%	9,953	100%
Endo Ctr North	0	2	4,116	4,816	6,237	51.5%	6,237	100%
Endo Ctr West	0	2	2,945	3,749	4,929	67.4%	4,929	100%
TN Endo Ctr	0	3	5,543	7,012	7,081	27.7%	7,012	99%
Total	**12**	**16**	**32,222**	**39,788**	**40,115**	**24.5%**	28,452	**70.9%**

*Notes: * The utilization is based on fiscal year (FY) data reported by the providers to TDH in their Joint Annual Reports. **Applicant's revised amount reported to TDH during preparation of the application (copies are attached in application)*
Sources: Joint Annual Report, applicant's internal data

The table above reflects the following:

- Including the applicant, four (4) of the 7 ASTCs noted in the table performed only endoscopy surgical cases in 2014.
- Of the 3 multi-specialty ASTCs, endoscopy procedures accounted for a combined average of approximately 2.7% of their 11,915 total cases in 2014.
- There was a 24.5% combined utilization increase in total outpatient surgery cases in 2014.
- None of the 7 ASTCs in the applicant's service area experienced a decrease in utilization from 2012-2014.

Applicant's Historical and Projected Utilization

The applicant's historical and projected utilization for the most recent full calendar year (CY) periods is provided in the table below.

TEC Historical and Projected Utilization, CY 2012-CY2018

	CY2012	CY2013	CY2014	% Change '12-'14	CY2015 Projected	CY2016 Projected	CY2017 (Year 1) Projected	CY2018 (Year 2) Projected
Procedure Rooms	8	8	8	NC	8	8	6	6
Cases	11,462	11,251	9,652	-15.8%	9,560	9.656	12,852	12,981
Cases/Rm	1,433	1,406	1,207	-15.8%	1,195	1,207	2,142	2,164
% of 1,867 optimal standard	76.8%	75.3%	64.6%		64.0%	64.7%	114.7%	115.9%

The table above reflects the following:

- Utilization decreased by 15.8% from CY 2012- CY 2014.
- The applicant projects a 33% increase in utilization from CY 2014 to Year 1 of the project due to the return to a normal full day surgical schedule resulting in the transfer of cases being performed at other facilities in the PSA by some of the medical staff physicians.

Note to Agency members:

- ***In addition to the applicant facility, The owners of the applicant own two other endoscopic ASTCs in Knox Count: Endoscopy Center North and Endoscopy Center West.***
- ***The applicant projects growth of approximately 3,200 procedures in the proposed facility mainly from 2 physicians performing their cases elsewhere.***
- ***Dr. Matthew Moore is expected to bring 900 new cases annually. 600 cases will come from Endoscopy Center North and Endoscopy Center West plus 300 from normal practice growth. The cases per room for these two facilities combined are expected to decrease from 2,817 to 2,667.***
- ***Dr. Jeff Gilbert expects to bring 2,200 new cases annually, 440 cases from Methodist Medical Center (MMC) in Oak Ridge (Anderson County) and 1,760 cases from the Tennessee Endoscopy Center in Maryville (Blount County). The cases per room at MMC are projected to decrease from 536 per room to 502. The cases per room at Tennessee Endoscopy Center are expected to decrease from 1,613 to 1,026.***

- Utilization in the existing facility with 8 procedure rooms is significantly below the 1,867 standard for optimal capacity primarily due to the facility's half-day surgical schedule implemented in 2012 to comply with Medicare requirements.
- Utilization at the proposed new facility with 6 procedure rooms is projected at approximately 114.7% of the standard in CY2017 (Year1).
- For additional information see applicant's table on page 44 of the application.

Project Cost

The total project cost is $13,791,719.00. Major costs are as follows:

- Facility Lease (15 year) - $6,910,800, or 50.1% of total cost. *Note: for CON purposes, the lease cost is higher than the estimated $4,037,000 fair market value (FMV) of the proposed facility as identified on page 46 of the application.*
- Construction Costs for applicant's build-out & renovation of proposed facility – $4,300,124 or 31.2% of total cost
- Moveable equipment - $1,618,987 or 11.7% of the total cost.
- For other details on Project Cost, see the Project Cost Chart on page 47 of the application.

Financing

The applicant states that the actual capital outlay needed to support the project amounts to approximately $6,880,919 or 49.9% of the total project cost.

- Funding will be provided by AmSurg in the form of a loan to the applicant LLC.
- A letter dated August 10, 2015 from Claire Gumli, CFO and Executive Vice President of AmSurg, attests to the availability of funding to cover the projected costs of the proposed project.
- Review of AmSurg's financial statements revealed current assets of $586,687,000 and current liabilities of $286,085,000 for the fiscal period ending 12/31/2014 for a current ratio of 2.05 to 1.0.

Historical Data Chart

Highlights of the Historical Data Chart in the application reflect the following:

- Gross operating revenue was $18,736,599 on 11,462 cases in CY2012 decreasing by 6.8% to $17,454,957 on 9,652 cases in CY2014 ($1,808/case).
- After deductions for contractual allowances, charity and bad debt, net operating revenue decreased by approximately 6.5% from $6,028,796 in CY2012 to $5,173,122 in CY2014 ($536/case).
- Operating expenses averaged approximately $4,700,543 per year or approximately 24.9% of average annual gross operating revenue during the period.
- Salaries and wages operating expense accounted for approximately 56.4% of total operating expenses in 2014.
- Management fees to affiliates (AmSurg Corp) were unchanged at $50,000 in each of the 3 fiscal year periods.
- Net operating income (NOI) was favorable in each of the 3 years noted in the chart at approximately 5.1% of gross operating revenue in 2012 decreasing to 4.3% of gross operating revenue in 2014.

Projected Data Chart

A revised Projected Data Chart containing minor corrections to the "Capital Expenditures" expense item (loan repayment amounts) was provided by the applicant in Item 7 of Supplemental 1. The Projected Data Chart reflects the following:

- The applicant projects $23,474,349 of total gross operating revenue on 12,852 cases in Year 1 increasing by approximately 2.0% to $23,946,184 on 12,981 cases in Year 2 ($1,845/case).
- Charity Care amounts to $1,371,522 in Year 2. This amount calculates to approximately 106 cases in Year Two ($1,371,522/12,981 cases).
- Net operating revenue after bad debt, charity care, and contractual adjustments is expected to reach $7,009,056 or approximately 29.2% of total gross revenue in Year Two.
- Operating expenses average approximately $6,040,000 per year or approximately 25.5% of gross operating revenue during the period.
- The 2 largest categories of operating expenses include Salaries and Wages and Other Expenses. These costs amount to approximately 47.8% and 19.1%, respectively, of total operating expenses in Year 2.
- Net operating income less capital expenditures for the applicant will equal $87,785 in Year One decreasing to $50,179 in Year Two due to slight changes in operating expenses such as salaries, supplies and rent. The operating margin amounts to approximately 0.2% of gross operating revenue in Year 2. However, by excluding depreciation expense, NOI appears to calculate to $682,134 for a favorable margin of approximately 2.85% in Year 2.

Charges

In Year One of the proposed project, the average endoscopy charges are as follows:

- The proposed average gross charge is $1,827/case in Year 1 (2017) from approximately $1,808/case in CY2014.
- The average deduction is approximately $1,287/case or approximately 70.4% of gross operating revenue in Year 1.
- An overview of the applicant's charges, including a comparison to Medicare allowable charges and charges of other similar endoscopy facilities is provided on pages 54 - 56 of the application.

Medicare/TennCare Payor Mix

- TennCare- Charges will equal $2,487,434 in Year One representing 1% of total gross revenue.

- Medicare- Charges will equal $14,084,609 in Year One representing 60% of total gross revenue.

Staffing

Overall, the applicant will increase staffing from 42.2 full time equivalent employees (FTE) to 49.5 FTE in Year 1 to support the proposed 6 procedure room facility at its new location in Knoxville less than 2 miles from the existing ASTC. The proposed facility will be supported by TEC's medical staff physicians (12 presently) and by certified registered nurse anesthetists provided through a contractual arrangement with AmSurg Chattanooga Anesthesia, LLC. In addition to these parties, the applicant proposes to use the following direct patient care FTE staff in Year 1:

- 13.6 FTE Registered Nurses
- 2.5 FTE Licensed Practical Nurses
- 8.0 FTE Endoscopy Techs
- 2.7 FTE Medical Assistants

Non-clinical amounts to approximately 23.7 FTE in Year 1 and includes the facility administrator, receptionists, schedulers, billing and medical records personnel.

Licensure/Accreditation

The Endoscopy Center of Knoxville is licensed by the Tennessee Department of Health, Division of Health Care Facilities, and is accredited by the Accreditation Association for Ambulatory Health Care (AAAHC). The AAAHC award was issued in October 2012 and expires in October 2015.

Corporate documentation, real estate lease, and detailed demographic information are on file at the Agency office and will be available at the Agency meeting.

Should the Agency vote to approve this project, the CON would expire in **two** years. The applicant seeks to open the ASTC in January 2017.

CERTIFICATE OF NEED INFORMATION FOR THE APPLICANT

There are no other Letters of Intent, denied or pending applications, or outstanding Certificates of Need for this applicant.

AmSurg Corp has a financial interest in this project and the following:

Outstanding Certificates of Need

The Chattanooga Endoscopy Center, CN1506-024A has a Certificate of Need that will expire on October 1, 2017. The project was approved at the September 23, 2015 Agency meeting for the relocation of its existing single specialty ASTC

approved in The Center for Digestive Disorders and Clinical Research, P.C., CN9608-060A, located at 2341 McCallie Avenue, Suite 201, Chattanooga (Hamilton County), Tennessee to an existing building at 1501 Riverside Drive, Suite 117 in Chattanooga, a distance of approximately 3 miles. As part of the project, the applicant will expand from 3 procedure rooms to 5 rooms (with a 6th room to be shelled in for future use) in order to meet its current and projected growth in patient volumes at the new facility. The estimated project cost is **$8,623,911.00.** *Project Status: This application was recently approved.*

CERTIFICATE OF NEED INFORMATION FOR OTHER SERVICE AREA FACILITIES:

There are no other Letters of Intent, denied or pending applications, or outstanding Certificates of Need for other health care organizations in the service area proposing this type of service.

PLEASE REFER TO THE REPORT BY THE DEPARTMENT OF HEALTH, DIVISION OF HEALTH STATISTICS, FOR A DETAILED ANALYSIS OF THE STATUTORY CRITERIA OF NEED, ECONOMIC FEASIBILITY, AND CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE IN THE AREA FOR THIS PROJECT. THAT REPORT IS ATTACHED TO THIS SUMMARY IMMEDIATELY FOLLOWING THE COLOR DIVIDER PAGE.

PJG; 9/30/2015

LETTER OF INTENT

LETTER OF INTENT -- HEALTH SERVICES & DEVELOPMENT AGENCY

The Publication of Intent is to be published in the Knoxville News Sentinel, which is a newspaper of general circulation in Knox County, Tennessee, on or before August 9, 2015, for one day.

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. Sections 68-11-1601 et seq., and the Rules of the Health Services and Development Agency, that The Endoscopy Center (an ambulatory surgical treatment center), owned by The Endoscopy Center of Knoxville, L.P. (a limited partnership), and managed by AmSurg Corp (a corporation), intends to file an application for a Certificate of Need to relocate from 801 Weisgarber Road, Suite 100, Knoxville, TN 37950 to an unaddressed site in the northwest quadrant of the intersection of Middlebrook Pike (TN 169) and Dowell Springs Boulevard in Knoxville, a distance of approximately 1.4 miles, and to reduce its procedure room complement from eight (8) to six (6) rooms. The project cost for CON purposes is estimated at $14,000,000, of which approximately $6,500,000 will be the actual capital cost. The balance consists of long-term lease payments that must be included under CON rules.

This facility is currently licensed by the Board for Licensing Health Care Facilities as a single specialty ambulatory surgical treatment center limited to endoscopy. The relocation will not change the facility's license classification. The project does not contain major medical equipment or initiate or discontinue any other health service; and it will not affect any facility's licensed bed complements.

The anticipated date of filing the application is on or before August 14, 2015. The contact person for the project is John Wellborn, who may be reached at Development Support Group, 4219 Hillsboro Road, Suite 210, Nashville, TN 37215; (615) 665-2022.

John L. Wellborn 8-10-15 jwdsg@comcast.net

(Signature) (Date) (E-mail Address)

COPY

The Endosocopy Center of Knoxville

CN1508-030

DSG Development Support Group

AUG 14 '15 PM 1:49

August 14, 2015

Melanie Hill, Executive Director
Tennessee Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

RE: CON Application Submittal
The Endoscopy Center of Knoxville--Relocation and Capacity Reduction
Knox County

Dear Mrs. Hill:

This letter transmits an original and two copies of the subject application. The affidavit and filing fee are enclosed.

I am the contact person for this project. Please advise me of any additional information you may need. We look forward to working with the Agency on this project.

Respectfully,

John Wellborn

John Wellborn
Consultant

4219 Hillsboro Road, Suite 203
Nashville, TN 37215

jwdsg@comcast.net

Tel 615.665.2022
Fax 615.665.2042

THE ENDOSCOPY CENTER (KNOXVILLE)

CERTIFICATE OF NEED APPLICATION TO CHANGE LOCATION AND TO REDUCE SURGICAL CAPACITY

Submitted August 2015

PART A

1. Name of Facility, Agency, or Institution

The Endoscopy Center		
Name		
Unaddressed site at northwest quadrant of the intersection of Middlebrook Pike (TN 169) and Dowell Springs Boulevard		Knox
Street or Route		*County*
Knoxville	TN	37909
City	*State*	*Zip Code*

2. Contact Person Available for Responses to Questions

John Wellborn		Consultant	
Name		*Title*	
Development Support Group		jwdsg@comcast.net	
Company Name		*E-Mail Address*	
4219 Hillsboro Road, Suite 210	Nashville	TN	37215
Street or Route	*City*	*State*	*Zip Code*
CON Consultant	615-665-2022	615-665-2042	
Association With Owner	*Phone Number*	*Fax Number*	

3. Owner of the Facility, Agency, or Institution

The Endoscopy Center of Knoxville, L.P.		615-240-3702
Name		*Phone Number*
c/o Amsurg Corp, 1A Burton Hills Boulevard		Davidson
Street or Route		*County*
Nashville	TN	xxxxx
City	*State*	*Zip Code*

4. Type of Ownership or Control (Check One)

A. Sole Proprietorship		F. Government (State of TN or Political Subdivision)	
B. Partnership		G. Joint Venture	
C. Limited Partnership	x	H. Limited Liability Company	
D. Corporation (For-Profit)		I. Other (Specify):	
E. Corporation (Not-for-Profit)			

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS

5. *Name of Management/Operating Entity (If Applicable)*

AmSurg Corp		
Name		
1 Burton Hills Boulevard		Davidson
Street or Route		*County*
Nashville	TN	37215
City	*State*	*Zip Code*

6. *Legal Interest in the Site of the Institution (Check One)*

A. Ownership		D. Option to Lease	
B. Option to Purchase		E. Other (Specify):	
C. Lease of 15 Years	x		

7. *Type of Institution (Check as appropriate—more than one may apply)*

A. Hospital (Specify): General		I. Nursing Home	
B. Ambulatory Surgical Treatment Center (ASTC) Multi-Specialty		J. Outpatient Diagnostic Center	
C. ASTC, Single Specialty	x	K. Recuperation Center	
D. Home Health Agency		L. Rehabilitation Center	
E. Hospice		M. Residential Hospice	
F. Mental Health Hospital		N. Non-Residential Methadone	
G. Mental Health Residential Faclity		O. Birthing Center	
H. Mental Retardation Institutional Habilitation Facility (ICF/MR)		P. Other Outpatient Facility (Specify):	
		Q. Other (Specify):	

8. *Purpose of Review (Check as appropriate—more than one may apply*

A. New Institution		G. Change in Bed Complement Please underline the type of Change: Increase, Decrease, Designation, Distribution, Conversion, Relocation	
B. Replacement/Existing Facility		H. Change of Location	x
C. Modification/Existing Facility		I. Other (Specify):	
D. Initiation of Health Care Service as defined in TCA Sec 68-11-1607(4) (Specify)		Reduction of Procedure Rooms	x
E. Discontinuance of OB Service			
F. Acquisition of Equipment			

9. *Bed Complement Data* ***NA***

(Please indicate current and proposed distribution and certification of facility beds.)

	Current Licensed Beds	CON approved beds (not in service)	Staffed Beds	Beds Proposed (Change)	TOTAL Beds at Completion
A. Medical					
B. Surgical					
C. Long Term Care Hosp.					
D. Obstetrical					
E. ICU/CCU					
F. Neonatal					
G. Pediatric					
H. Adult Psychiatric					
I. Geriatric Psychiatric					
J. Child/Adolesc. Psych.					
K. Rehabilitation					
L. Nursing Facility (non-Medicaid certified)					
M. Nursing Facility Lev. 1 (Medicaid only)					
N. Nursing Facility Lev. 2 (Medicare only)					
O Nursing Facility Lev. 2 (dually certified for Medicare & Medicaid)					
P. ICF/MR					
Q. Adult Chemical Dependency					
R. Child/Adolescent Chemical Dependency					
S. Swing Beds					
T. Mental Health Residential Treatment					
U. Residential Hospice					
TOTAL					

10. Medicare Provider Number:	3287442
Certification Type:	Ambulatory Surgical Treatment Center
11. Medicaid Provider Number:	3287442
Certification Type:	Ambulatory Surgical Treatment Center

12. & 13. See page 4

A.12. IF THIS IS A NEW FACILITY, WILL CERTIFICATION BE SOUGHT FOR MEDICARE AND/OR MEDICAID?

The applicant is an existing facility that already participates in both Medicare and TennCare/Medicaid. A change of site will not affect those certifications because the licensee will remain unchanged.

A.13. IDENTIFY ALL TENNCARE MANAGED CARE ORGANIZATIONS / BEHAVIORAL HEALTH ORGANIZATIONS (MCO'S/BHO'S) OPERATING IN THE PROPOSED SERVICE AREA. WILL THIS PROJECT INVOLVE THE TREATMENT OF TENNCARE PARTICIPANTS? Yes IF THE RESPONSE TO THIS ITEM IS YES, PLEASE IDENTIFY ALL MCO'S WITH WHICH THE APPLICANT HAS CONTRACTED OR PLANS TO CONTRACT.

DISCUSS ANY OUT-OF-NETWORK RELATIONSHIPS IN PLACE WITH MCO'S/BHO'S IN THE AREA.

The Endoscopy Center of Knoxville is contracted with three of Tennessee's four MCO's. At the time of filing this application, it has submitted its credentialing application to Amerigroup and is awaiting an agreement.

Table One: Contractual Relationships with Service Area MCO's	
Available TennCare MCO's	**Applicant's Relationship**
AmeriGroup	contract requested and pending
United Healthcare Community Plan	contracted
BlueCare	contracted
TennCare Select	contracted

SECTION B: PROJECT DESCRIPTION
B.I. PROVIDE A BRIEF EXECUTIVE SUMMARY OF THE PROJECT NOT TO EXCEED TWO PAGES. TOPICS TO BE INCLUDED IN THE EXECUTIVE SUMMARY ARE A BRIEF DESCRIPTION OF PROPOSED SERVICES AND EQUIPMENT, OWNERSHIP STRUCTURE, SERVICE AREA, NEED, EXISTING RESOURCES, PROJECT COST, FUNDING, FINANCIAL FEASIBILITY AND STAFFING.

Proposed Services and Equipment

- The Endoscopy Center in Knoxville is an ambulatory surgical treatment center (ASTC) limited to endoscopy. It has operated for almost 29 years at its current location in Knox County. It has eight procedure rooms.

- This application is to relocate the facility 1.4 miles within Knox County, to larger leased space in a building to be constructed in the Dowell Springs development north of I-40. The project site is across Middlebrook Pike from the future site of the Tennova Physicians Regional Medical Center (an unrelated facility). In the move, The Endoscopy Center will reduce its capacity from eight (8) to six (6) procedure rooms. The Center will lease one floor of the new building. Gastroenterology Associates (GIA), a physician group practice who are the medical staff of the Center, will also lease a floor there.

Ownership Structure

- The facility is owned by The Endoscopy Center of Knoxville, L.P. This limited partnership's general partner is AmSurg KEC, Inc., a wholly owned subsidiary of AmSurg Corp. The L.P.'s limited partner is "The Endoscopy Center" (a Tennessee general partnership composed of nine gastroenterologists in the medical practice named Gastrointestinal Associates). AmSurg Corp has a management contract with the ASTC.

- Attachment A.4 contains more details, an organization chart, and information on the Tennessee facilities owned by AmSurg.

Service Area

- The ASTC's primary service area, from which 82% of its cases come, consists of Knox, Sevier, Jefferson, Blount, Anderson, and Hamblen Counties in East Tennessee.

Need

- When this facility opened in 1986, it shared some support spaces with Gastrointestinal Associates ("GIA"), its medical staff's private group practice office. Several years ago, Medicare compelled surgery centers nationwide to stop sharing space with adjoining medical practices, including even shared waiting areas. The ASTC had no adjoining space into which it could expand to create such a separation. So the ASTC and the medical practice obtained Medicare and State licensing approval for the ASTC to use the space exclusively, from 7 AM to 12 noon, while the practice would use the space from 12 noon to 5 PM. This reduced the ASTC's surgical schedule (formerly 7 AM-5PM) by 50% in mid-2013.

• That limitation to half-time operation, the subsequent death of the Endoscopy Center's busiest surgeon, and the obsolete design of the small, almost 29-year-old facility all combined to decrease annual utilization after June of 2013: from 11,251 cases in CY 2013 to a projected 9,560 cases in CY2015, the current year.

• This project will address those limitations by providing a 7 AM to 4 PM five-day-a-week, efficient workspace in a new building with excellent patient access, not far from the ASTC's current location. The Endoscopy Center has commitments from two physicians who will add 3,100 cases at the new location in CY2017. In its second year of operation at the new site, the Center will perform 12,981 total cases. The State health Plan optimal standard (70% occupancy) of 1,867 cases per room indicates a need for 7.0 procedure rooms. AmSurg's own internal standard indicates a need for 6 rooms. This application is proposing 6 procedure rooms, which will reduce service area capacity by 2 procedure rooms.

• Apart from the need to escape capacity limitations of a half-day surgical schedule, The Endoscopy Center's almost 29-year old, tiny 3,686-SF floor plan no longer meets current endoscopy center design standards. Much larger, more efficient, and more comfortable spaces are essential to provide an optimal care experience for these patients.

Existing Resources

• In the primary service area, seven surgery centers reported performing endoscopies in one or more years from FYE 2012 to FYE 2014. Their utilization of their procedure rooms was last reported at 1,667 cases per room in FYE 2014--89% of the State Health Plan's optimal standard for procedure room utilization.

Project Cost, Funding, Financial Feasibility

• The cost for CON purposes is estimated at $13,791,719. However, that includes the new location's lease payments for fifteen years. Excluding that, the applicant's actual capital expenditure required for the project is estimated at $6,880,919. That will be the applicant's cost for obtaining the CON and for building out and equipping the floor space it will lease for the project. The applicant's costs will be funded by a loan from AmSurg Corp., the general partner and manager of this facility. (AmSurg is not funding the developer's cost of providing the shelled floor). The facility reported a positive operating margin in 2014. Continued positive operating margins are anticipated at the new location, with increased utilization.

Staffing

• The Endoscopy Center (Knoxville) today has 42.2 FTE's. In Year Two at the new location, the facility projects having 50.7 FTE's on staff.

B.II. PROVIDE A DETAILED NARRATIVE OF THE PROJECT BY ADDRESSING THE FOLLOWING ITEMS AS THEY RELATE TO THE PROPOSAL.

B.II.A. DESCRIBE THE CONSTRUCTION, MODIFICATION AND/OR RENOVATION OF THE FACILITY (EXCLUSIVE OF MAJOR MEDICAL EQUIPMENT COVERED BY T.C.A. 68-11-1601 *et seq.)* INCLUDING SQUARE FOOTAGE, MAJOR OPERATIONAL AREAS, ROOM CONFIGURATION, ETC.

Physical Description of the Project

The applicant facility, The Endoscopy Center ("TEC") is a single-specialty ambulatory surgical treatment center limited to endoscopy. It has been located at 801 Weisgarber Road in Knoxville for almost 29 years. It has 8 procedure rooms.

In this application, The Endoscopy Center proposes to move in late 2016 to leased second-floor space in a new building that will be constructed in the Dowell Springs area of central Knox County, close to I-40. The 4.53-acre site is 1.4 miles from TEC's present location. The site is in the northwest quadrant of the intersection of Dowell Springs Boulevard and Middlebrook Pike (TN Highway 169)--directly across Middlebrook Pike from the future site of the Physicians Regional Medical Center.

At the new location, TEC will utilize 16,732 usable SF of space, containing 6 endoscopy procedure rooms--2 fewer rooms than at present. It will expand its preparation and recovery areas from its current 7 pre-op and post-op recovery stations, to 18 pre-op and post-op recovery stations. The design includes two large waiting rooms--one for patients and another for waiting families. The plan also provides all required support areas, such as staff lockers, showers, and break room; a biohazard room, and supply storage.

A floor plan of the proposed new space is attached following this page. Additional plans are in the Attachments.

ROOM LISTING

ROOM NO.	NAME
200	WAITING 33 SEATS
201	CORRIDOR
202	CORRIDOR
203	PATIENT TOILET
204	SELF CHECK-IN
205	GREETER
206	PATIENT TOILET
207	CORRIDOR
208	UNIT DIRECTOR
209	PATIENT TOILET
210	PATIENT TOILET
211	PRE-OP
212	PRE-OP
213	NURSE STATION
214	PRE-OP
215	PRE-OP

ROOM LISTING

ROOM NO.	NAME
216	PRE-OP
217	PATIENT TOILET
218	PRE-OP
219	SOILED UTILITY
220	PROCEDURE
221	PROCEDURE
222	PROCEDURE
223	PROCEDURE
224	CORRIDOR
225	SOILED WORKROOM
226	CORRIDOR
227	SCOPES STORAGE
228	PROCEDURE
229	WASH
230	PRE-WASH
231	LINEN

ROOM LISTING

ROOM NO.	NAME
232	PROCEDURE/FLUOR
233	PATIENT TOILET
234	JANITOR
235	AIR LOCK
236	GURNEY
237	BIO HAZARD
238	REC'G
239	SUPPLY
240	LOCKER
241	SHOWER
242	STAFF TOILET
243	STAFF TOILET
244	SHOWER
245	LOCKER
246	CORRIDOR
247	BREAK ROOM

ROOM LISTING

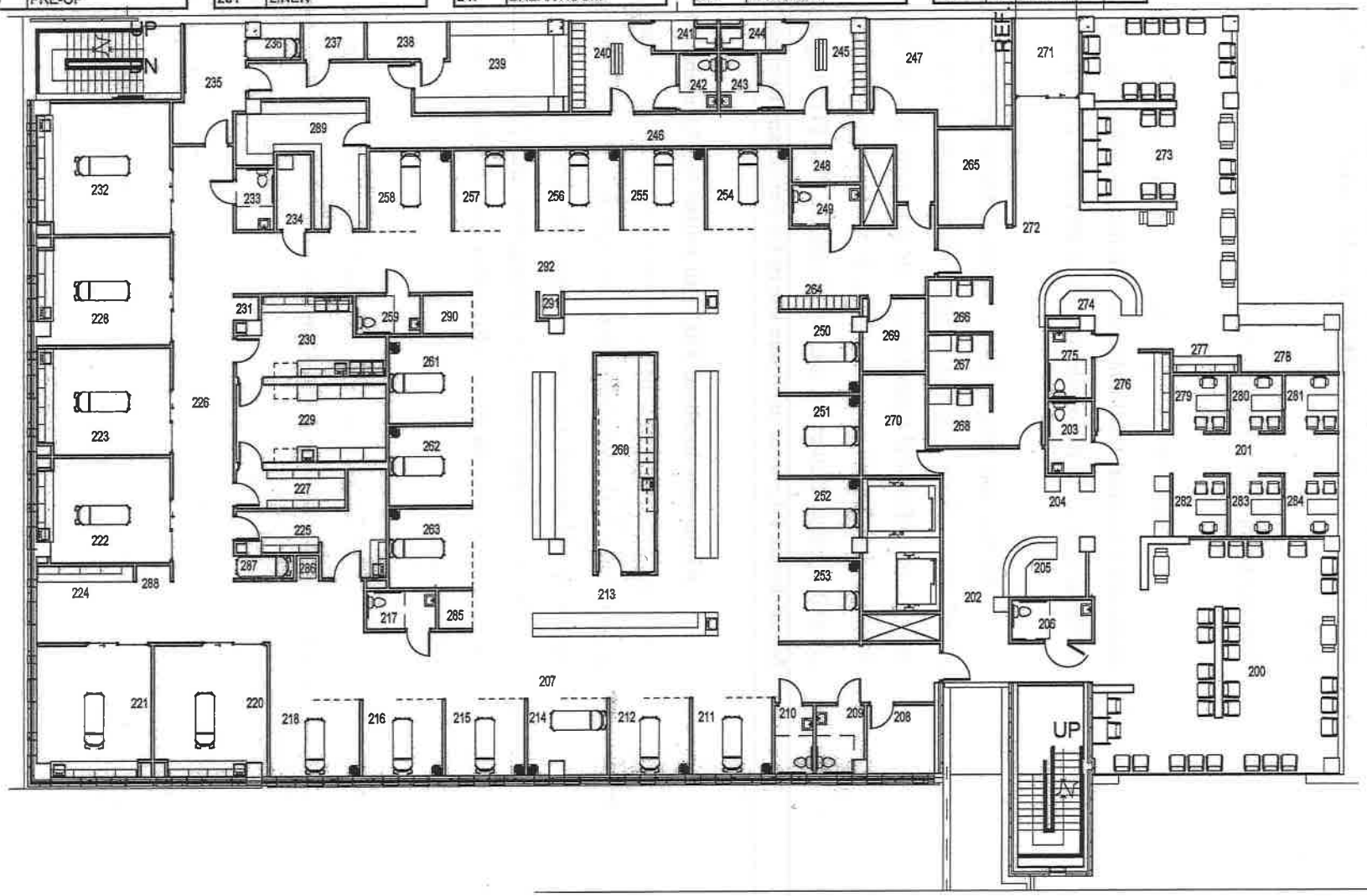
ROOM NO.	NAME
248	CLOSET
249	PATIENT TOILET
250	RECOVERY
251	RECOVERY
252	RECOVERY
253	RECOVERY
254	RECOVERY
255	RECOVERY
256	RECOVERY
257	RECOVERY
258	RECOVERY
259	PATIENT TOILET
260	NURSE WORK ROOM
261	RECOVERY
262	RECOVERY
263	RECOVERY

ROOM LISTING

ROOM NO.	NAME
264	LOCKERS
265	CON/WK ROOM
266	SCHEDULE
267	SCHEDULE
268	SCHEDULE
269	ANESTHESIA OFFICE
270	ELECT/MECH
271	AIR LOCK
272	CORRIDOR
273	WAITING 28 SEATS
274	CHECK OUT
275	STAFF TOILET
276	WORK ROOM
277	BEV BAR
278	KIDS
279	PATIENT ADV.

ROOM LISTING

ROOM NO.	NAME
280	PATIENT ADV.
281	PATIENT ADV.
282	PATIENT ADV.
283	PATIENT ADV.
284	PATIENT ADV.
285	LINEN WHEEL CHAIR
286	CRASH
287	GURNEY
288	LINEN
289	SUPPLY
290	LINEN WHEEL CHAIR
291	CRASH
292	CORRIDOR



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A NEW FACILITY FOR:
THE ENDOSCOPY CENTER
DOWELL SPRINGS

26

PROJECT #:	14075
DATE:	06/22/2015
SHEET #:	CON
REFERENCE:	

Construction Scope and Cost

Tables Two-A and -B below summarize the scope of proposed changes in size and the applicant's build-out/renovation costs at the proposed Dowell Springs location.

Table Two-A: Summary of Construction and Changes in Size	
Space At Current Site	3,686 SF
Space At Proposed Location	16,732 SF
Area of New Construction By Lessee	0 SF
Area of Build-out or Renovation by Lessee	16,732 SF
Total Construction Project	16,732 SF

Table Two-B: Construction Costs of This Project			
	Applicant's Renovation	**Applicant's New Construction**	**Applicant's Total Construction**
Square Feet	16,732 SF	0	16,732 SF
Construction Cost	$4,300,124	0	$4,300,124
Constr. Cost PSF	$257 PSF	0	$257 PSF

Operational Schedule and Open Medical Staff

The Endoscopy Center will expand its operating hours of 7 am to 12 noon, to 7 am to 4 pm, five days per week, Monday through Friday, throughout the year. Calendar year 2017 is projected to be the first full year of operation at the new location. The facility has, and will continue to have, an open medical staff, for appropriately accredited gastroenterologists.

Cost and Funding

The cost for CON purposes is estimated at $13,791,719. However, that includes the new location's lease expense over fifteen years. Excluding that operational cost, the applicant's real capital cost for completing and occupying its floor at the new location is estimated at $6,408,504. All of that will be provided in the form of a loan from AmSurg Corp, the general partner of the applicant.

Ownership of the Applicant

The Endoscopy Center is, and will continue to be, owned by The Endoscopy Center of Knoxville, L.P. (the CON applicant). That L.P.'s 51% general partner is AmSurg KEC, Inc., a subsidiary of AmSurg Corp, a publicly traded company. The L.P.'s 49% limited partner is "The Endoscopy Center", which is a Tennessee general partnership composed of nine gastroenterologists in the medical practice named Gastroenterology Associates, or "GIA". Physician owners of the limilted partner are:

Table Two-C: The Endoscopy Center of Knoxville, L.P.			
General Partner (51%) AmSurg KEC, Inc.		**Limited Partner (49%) The Endoscopy Center (A Tennessee General Partnership)**	
Owner	**Percent of General Partner**	**Owners (All M.D.'s in GIA)**	**Percent of Ltd Partner**
		1. Barry V. Mayes	11.111%
AmSurg Corp	100%	2. Sarkis J. Chobanian	11.111%
		3. Charles M. O'Connor	11.111%
		4. Meade C. Edmunds	11.111%
		5. John M. Haydek	11.111%
		6. Maria B. Newman	11.111%
		7. Raj I. Narayani	11.111%
		8. Steven J. Bindrim	11.111%
		9. Scott L. Wilhoite	11.111%

Ownership interests in the applicant, and in the entities owning the applicant, will not change in this project. The ASTC's surgical staff now consists of the 9 GIA gastroenterologists listed above, and 3 other GIA gastroenterologists (Drs. Matthew Moore, Johnny Altavil, and Bergein Overholt) who are not limited partners. Dr. Jeff Gilbert will join GIA in September 2015; he will have privileges at the ASTC, but will not be a limited partner.

APPLICANTS WITH HOSPITAL PROJECTS (CONSTRUCTION COST IN EXCESS OF $5 MILLION) AND OTHER FACILITY PROJECTS (CONSTRUCTION COST IN EXCESS OF $2 MILLION) SHOULD COMPLETE THE SQUARE FOOTAGE AND COSTS PER SQUARE FOOTAGE CHART....

See Attachment B.II.A.

PLEASE ALSO DISCUSS AND JUSTIFY THE COST PER SQUARE FOOT FOR THIS PROJECT.

The HSDA has calculated 2012-2014 ASTC construction cost averages for approved projects. However, there were too few samples to calculate renovation or new construction costs separately.

Ambulatory Surgery Center Construction Cost PSF Years: 2012-2014			
	Renovated Construction	New Construction	Total Construction
1st Quartile	$0/sq ft	$0/sq ft	$113.55/sq ft
Median	$0/sq ft	$0/sq ft	$150.00/sq ft
3rd Quartile	$0/sq ft	$0/sq ft	$174.88/sq ft

Source: HSDA Registry; CON approved applications for years 2012 through 2014

However, surgery center construction projects approved by the HSDA in 2011-2013 had the following construction costs per SF:

Ambulatory Surgery Center Construction Cost PSF Years: 2011-2013			
	Renovated Construction	New Construction	Total Construction
1st Quartile	$95.04/sq ft	$174.88/sq ft	$113.55/sq ft
Median	$113.55/sq ft	$223.62/sq ft	$162.00/sq ft
3rd Quartile	$150.00/sq ft	$269.76/sq ft	$223.62/sq ft

Source: HSDA Registry; CON approved applications for years 2011 through 2013

The applicant's build-out (renovation) cost of $257 PSF is above the HSDA's last calculated average third quartile cost for ASTC's. But this is reasonable due to the steady annual increase in construction costs since 2011, and the costs in the Knoxville market for such projects. The construction will be paid for in 2016, which is four years beyond the midpoint of the HSDA 2011-13 range.

Table Two-B (Repeated): Construction Costs of This Project			
	Applicant's Renovation	**Applicant's New Construction**	**Applicant's Total Construction**
Square Feet	16,732 SF	0	16,732 SF
Construction Cost	$4,300,124	0	$4,300,124
Constr. Cost PSF	$257 PSF	0	$257 PSF

IF THE PROJECT INVOLVES NONE OF THE ABOVE, DESCRIBE THE DEVELOPMENT OF THE PROPOSAL.

Not applicable.

B.II.B. IDENTIFY THE NUMBER AND TYPE OF BEDS INCREASED, DECREASED, CONVERTED, RELOCATED, DESIGNATED, AND/OR REDISTRIBUTED BY THIS APPLICATION. DESCRIBE THE REASONS FOR CHANGE IN BED ALLOCATIONS AND DESCRIBE THE IMPACT THE BED CHANGE WILL HAVE ON EXISTING SERVICES.

Not applicable to an ambulatory surgical treatment facility.

B.II.C. AS THE APPLICANT, DESCRIBE YOUR NEED TO PROVIDE THE FOLLOWING HEALTH CARE SERVICES (IF APPLICABLE TO THIS APPLICATION): (NEW SERVICE LIST OMITTED)....

Not applicable. No services are being added to this facility. This is a relocation of an existing facility with no change in its scope of services.

B.II.D. DESCRIBE THE NEED TO CHANGE LOCATION OR REPLACE AN EXISTING FACILITY.

The Need to Relocate to Another Building

Historically, The Endoscopy Center on Weisgbarber Road in Knoxville was one of the earliest endoscopic ambulatory surgery centers developed in Tennessee. It opened in 1986, almost three decades ago. It was also the Knoxville region's largest ASTC provider of outpatient endoscopic cases until July of 2013. In the fiscal year ending June 2013, of the seven area ASTC's who performed endoscopic cases, The Endoscopy Center performed almost 30% of all those cases and performed 64% more cases than the next-highest provider.

Between 2010 and 2013, Medicare directed surgery centers nationwide to cease all space-sharing arrangements with adjoining physician practice offices. Up to that time, it was commonplace--and very economical--for surgery centers to share areas such as reception, waiting, and business with the physician group practices that constituted their medical staffs. The Endoscopy Center shared some spaces with its associated medical practice, Gastrointestinal Associates ("GIA").

Threatened with loss of Medicare reimbursement, but with no expansion room available in its Weisgarber Road building, and with lease commitments, The Endoscopy Center's only way to comply with Medicare's new space-sharing prohibition was to negotiate a temporary time-sharing agreement with the medical practice (GIA), that was acceptable to Medicare and to State Licensure. The agreement gave the Center exclusive use of the entire premises from 7 AM to noon daily, with GIA using the entire premises exclusively as a gastroenterology group practice office during the afternoons. This operational arrangement is still in effect.

The sudden reduction of *effective* surgical capacity by a required closure at noon, and the death of the center's busiest surgeon (who performed approximately 1,500 cases per year), caused the center's utilization to decline the following year by 15%--from 11,251 cases in CY2013 to a projected 9,560 cases in CY2015. With additional

physician recruitment since 2013, utilization is slowly increasing, but the limitation to half-day operation is a severe restraint on case referrals to this practice and to its ASTC. It is not sustainable to continue this truncated operating schedule indefinitely. Relocation to another site with complete separation of the endoscopy center from the GIA practice office is essential to restore normal utilization of this facility. GIA also needs to restore a normal workday for its group practice office, as its staff increases with new recruitment and as an aging population requires ever more endoscopic care.

It is also time to modernize The Endoscopy Center's physical space. Designed three decades ago, the current space has many limitations other than its mornings-only surgical schedule. AIA and State requirements have changed significantly in three decades.

More pre-op and recovery stations will be needed to accommodate increasing demand for services over the next several years. Their positioning for line-of-sight supervision needs to be improved. They need more hard-walled stations to provide patients with more privacy and quiet than is now possible with only curtained gurney bays. The Center needs more Pre-op stations to ensure efficient throughput of cases during busy periods. It needs more Recovery stations to avoid bottlenecks that tie up procedure rooms, i.e., when recovery stations are full and patients who have completed surgery have to recover in the procedure room itself, delaying that room's use for the next scheduled patient. One larger procedure room needs to be provided for specialized equipment to be used in certain cases.

Within the procedure rooms, electrical equipment needs to connect with power sources descending from the ceiling, rather than having wires trailing underfoot across procedure room floors. For optimal infection control, automatic doors are needed to replace hand-operated doors in some areas, so that (a) nurses transporting non-sterile scopes do not have to touch door handles, risking contamination of the handles, and (b) nurses transporting sterile scopes do not have to touch door handles, risking contamination of the scopes they carry.

Ambulance and non-ambulance patient access needs to be improved. Currently all patients come in the front door through the waiting room; and they leave the same

way. In the new location, a separate ambulance entry is provided, giving patients more privacy. And in the new design, families whose patients have been taken to surgery will wait for them in a second waiting area that is separate from the one for arriving patients and families. Discharge after recovery will be more private, with patient exits separated from the view of the waiting rooms. Airlocks will be provided for all-weather comfort and privacy in exiting the building, and for arriving ambulance patients.

Need For Six Procedure Rooms (Decrease of Two Rooms)

The facility's annualized CY2015 utilization based on January-June is 9,560 cases. In CY2016, at the current location, facility management projects that normal growth in physician referrals will increase utilization by at least 1%, to 9,656 cases. In CY2017, even at the current location, normal growth brought by existing medical staff will again increase utilization by 1%, to 9,752 cases.

But if the proposed relocation is approved, allowing normal full-day operation, an *additional* 3,100 new cases will be brought to the new location in CY2017 by two physicians who currently do not have room to perform their cases at this facility. Dr. Jeff Gilbert, an established Anderson County gastroenterologist, is joining the Center in late 2015. He projects bringing 2,200 of his current cases to the new location in CY2017. Dr. Matthew Moore will bring 900 cases--600 cases currently being performed at two Knox County endoscopy centers owned by this same applicant, plus 300 new cases from normal practice growth between 2015 and 2017. Dr. Gilbert's and Dr. Moore's letter attesting to these new cases are provided in the Attachments.

In CY2017, with a normal full-day surgical schedule resumed at the new location, and with Dr. Gilbert and Dr. Moore's transferred cases, The Endoscopy Center projects a first-year caseload of 12,852 cases. The following year the Center projects a continuing 1% increase in utilization, to 12,981 cases.

Table Three-A below shows that the projected occupancy on the proposed facility is consistent with the Guidelines of the State Health Plan. The Table shows surgical room utilization as a percent of three standards: (a) Amsurg's broad general goal

of performing 2,500 cases per room; (b) the State Health Plan's "optimal" goal of 1,867 cases per room (70% occupancy); and (c) the State Health Plan's definition of 100% occupancy for a procedure room.

The project will operate in Year Two (2018) at approximately 116% of the State Health Plan's optimal efficiency standard. It will operate at 86.6% of AmSurg's own higher expectation for this type of facility.

Table Three-A: The Endoscopy Center (Knoxville)
Historical and Projected Utilization 2012-2018 (Year Two)
Patients/Cases

Calendar Year	Procedure Rooms	Cases	Cases Per Room	Percent of AmSurg Optimal Cases of 2,500 / Rm	Percent of State Health Plan Optimal Cases of 1,867 / Rm	Percent of State Health Plan Full Capacity Cases of 2,667 / Rm
(Historical)						
CY 2012	8	11,462	1,433	57.3%	76.8%	53.7%
CY 2013	8	11,251	1,406	56.2%	75.3%	52.7%
CY 2014	8	9,652	1,207	48.3%	64.6%	45.3%
(Projected)						
CY 2015	8	9,560	1,195	47.8%	64.0%	44.8%
CY 2016	8	9,656	1,207	48.3%	64.7%	45.3%
CY 2017-Yr 1	**6**	**12,852**	**2,142**	**85.7%**	**114.7%**	**80.3%**
CY 2018-Yr 2	**6**	**12,981**	**2,164**	**86.6%**	**115.9%**	**81.1%**

Sources: FY2012-15 historical cases from AmSurg management and facility records; 2015 annualized on Jan-June. CY2016-18 projected cases from AmSurg management.

Converting this utilization into room need, Table Three-B on the following page shows the procedure rooms that the projected utilization needs under AmSurg's and the State Health Plan's standards. Under the State Health Plan's optimal occupancy standard, seven procedure rooms will be needed in CY2018, Year Two. AmSurg's standard indicates that with a need for 5.2 procedure rooms, 6 rooms will be appropriate and will provide room for future growth. Consistent with that, 6 rooms are being proposed in this application. That will be a decrease of 2 rooms from the current 8-room license.

Table Three-B: The Endoscopy Center (Knoxville) Procedure Room Need Based on AmSurg and State Health Plan Utilization Standards					
Year	**Procedure Rooms**	**Cases**	**Cases Per Room**	**Room Need At AmSurg Goal of 2500 Cases Per Room**	**Room Need At State Health Plan Optimal Standard of 1,867 Cases Per Room**
(Historical)					
CY 2012	8	11,462	1,433	4.6	6.1
CY 2013	8	11,251	1,406	4.5	6.0
CY2014	8	9,652	1,207	3.9	5.2
(Projected)					
CY 2015 Ann'd	8	9,560	1,195	3.8	5.1
CY 2016	8	9,656	1,207	3.9	5.2
CY 2017-Yr 1	**6**	**12,852**	**2,142**	**5.1**	**6.9**
CY 2018-Yr 2	**6**	**12,981**	**2,164**	**5.2**	**7.0**

Sources: Table Three-A.

Service Area Need for Services

The Center of Disease Controls website shows that colorectal cancer incidence in Tennessee is 40.1 to 42.6 persons per 100,000 population, in the third highest national quartile. However, Tennessee is one of twelve States in the highest quartile for deaths from that disease, at 16.5 to 19.9 persons per 100,000 population. This is linked to the fact that only 59.3% to 63.5% of Tennessee adults age 50-75 years are "up to date", i.e., compliant with, recommended periodic colon cancer screening guidelines. Screening endoscopies are essential to identify and surgically remove pre-cancerous polyps and early-stage colon cancers. Screening guidelines call for this procedure to be performed on all persons 50 years of age or older, every ten years--or every five years if high-risk. Table Three-C below shows potential cases of colon cancer in this project's service area.

Table Three-C: Potential Colon Cancer Patients, Primary Service Area

PSA County	Rate / 100,000	2015 Population	Predicted 2015 Cases
Anderson	40.1 to 42.6	76,949	31 - 33
Blount	40.1 to 42.6	129,973	52 - 55
Hamblen	40.1 to 42.6	64,438	26 - 27
Jefferson	40.1 to 42.6	54,482	22 - 23
Knox	40.1 to 42.6	459,124	184 - 196
Sevier	40.1 to 42.6	96,116	39 - 41
PSA Total		*881,082*	*353 - 375*

Source: CDC; TDH

B.II.E. DESCRIBE THE ACQUISITION OF ANY ITEM OF MAJOR MEDICAL EQUIPMENT (AS DEFINED BY THE AGENCY RULES AND THE STATUTE) WHICH EXCEEDS A COST OF $1.5 MILLION; AND/OR IS A MAGNETIC RESONANCE IMAGING SCANNER (MRI), POSITRON EMISSION TOMOGRAPHY (PET) SCANNER, EXTRACORPOREAL LITHOTRIPTER AND/OR LINEAR ACCELERATOR BY RESPONDING TO THE FOLLOWING:

1. For fixed site major medical equipment (not replacing existing equipment):
- **a. Describe the new equipment, including:**
  1. **Total Cost (As defined by Agency Rule);**
  2. **Expected Useful Life;**
  3. **List of clinical applications to be provided; and**
  4. **Documentation of FDA approval.**
- **b. Provide current and proposed schedule of operations.**

2. For mobile major medical equipment:
- **a. List all sites that will be served;**
- **b. Provide current and/or proposed schedule of operations;**
- **c. Provide the lease or contract cost;**
- **d. Provide the fair market value of the equipment; and**
- **e. List the owner for the equipment.**

3. Indicate applicant's legal interest in equipment (e.g., purchase, lease, etc.) In the case of equipment purchase, include a quote and/or proposal from an equipment vendor, or in the case of an equipment lease provide a draft lease or contract that at least includes the term of the lease and the anticipated lease payments.

Not applicable. No major medical equipment is proposed in this project.

B.III.A. ATTACH A COPY OF THE PLOT PLAN OF THE SITE ON AN 8-1/2" X 11" SHEET OF WHITE PAPER WHICH MUST INCLUDE:

1. **SIZE OF SITE (IN ACRES);**
2. **LOCATION OF STRUCTURE ON THE SITE;**
3. **LOCATION OF THE PROPOSED CONSTRUCTION; AND**
4. **NAMES OF STREETS, ROADS OR HIGHWAYS THAT CROSS OR BORDER THE SITE.**

PLEASE NOTE THAT THE DRAWINGS DO NOT NEED TO BE DRAWN TO SCALE. PLOT PLANS ARE REQUIRED FOR ALL PROJECTS.

See Attachment B.III.A.

B.III.B.1. DESCRIBE THE RELATIONSHIP OF THE SITE TO PUBLIC TRANSPORTATION ROUTES, IF ANY, AND TO ANY HIGHWAY OR MAJOR ROAD DEVELOPMENTS IN THE AREA. DESCRIBE THE ACCESSIBILITY OF THE PROPOSED SITE TO PATIENTS/CLIENTS.

The site is within five minutes' drive of Exit 388 (Papermill/Weisgarber Road) on I-40 in Knoxville, central to that city, and central to the region the project will serve. Interstates and good Federal and State highways connect Knoxville to all parts of the service area, whose residents look to Knoxville for tertiary, specialized care when that is not available in their home communities. City and regional location maps are provided in Attachment C, Need—3.

KAT (Knoxville Area Transit) operates bus service along Middlebrook Pike and up Dowell Springs Boulevard, already providing bus service directly by` the project site at the intersection of those two streets. Please see the KAT bus route map in Attachment C,Need--3, Service Area Maps.

The drive time Tables Four-A and -B on the following page provide driving distance and times between both the current and proposed sites, and major communities in the service area, and from the proposed site to other area ASTC's that currently perform endoscopic surgery.

The relocation will improve physical accessibility for the applicant's patients, because of its higher visibility in a stand-alone building, at a major intersection in the developing area of Dowell Springs, directly across the street from the future Physicians Regional Medical Center campus.

Table Four-A: Mileage and Drive Times From the Applicant's Current and Proposed Sites to Major Communities in the Project's Primary Service Area

		To Proposed Site		To Current Site	
County	**City**	**Miles**	**Minutes**	**Miles**	**Minutes**
Knox	Farragut	11.6	18 min.	12.3	17 min.
	Powell	9.0	19 min.	12.5	16 min.
	Halls Crossroads	14.3	20 min.	14.4	18 min.
	Seymour	19.1	33 min.	17.7	27 min.
Sevier	Sevierville	32.3	49 min.	30.9	44 min.
Jefferson	Jefferson City	34.7	43 min.	33.3	39 min.
Blount	Maryville	21.2	30 min.	19.9	27 min.
Anderson	Clinton	17.4	29 min.	20.7	29 min.
	Oak Ridge	19.4	27 min.	20.1	26 min.
Hamblen	Morristown	53.9	56 min.	52.6	53 min.
Average Drive Time			**32.4 min.**		**29.6 min.**

Source: Google Maps, June, 2015.

Table Four-B: Mileage and Drive Times Between the Project and Other ASTC's Performing Endoscopies in the Project's Tennessee Primary Service Area

Facility and Address	**County and State**	**Distance in Miles**	**Drive Time in Minutes**
Children's West Surgery Center 1020 Children's Way, Knoxville 37922	Knox TN	11.7	17 min.
Fort Sanders West OP Surgery Center 210 Ft. Sanders W. Boulevard, Knoxville 37909	Knox TN	9.4	16 min.
Parkwest Surgery Center 9430 Parkwest Boulevard, Knoxville 37923	Knox TN	6.7	12 min.
The Endoscopy Center North 629 Delozier Way, Powell 37849	Knox TN	11.3	18 min.
The Endoscopy Center West 11440 Parkside Drive, Knoxville 37934	Knox TN	12.3	19 min.
Tennessee Endoscopy Center 1706 E. Lamar Alexander Pkwy, Maryville 37804	Blount TN	22.1	31 min.

Source: Google Maps, July 2015.

B.IV. ATTACH A FLOOR PLAN DRAWING FOR THE FACILITY WHICH INCLUDES PATIENT CARE ROOMS (NOTING PRIVATE OR SEMI-PRIVATE), ANCILLARY AREAS, EQUIPMENT AREAS, ETC.

See attachment B.IV.

IV. FOR A HOME CARE ORGANIZATION, IDENTIFY

1. **EXISTING SERVICE AREA (BY COUNTY);**
2. **PROPOSED SERVICE AREA (BY COUNTY);**
3. **A PARENT OR PRIMARY SERVICE PROVIDER;**
4. **EXISTING BRANCHES AND/OR SUB-UNITS; AND**
5. **PROPOSED BRANCHES AND/OR SUBUNITS.**

Not applicable. The application is not for a home care organization.

C(I) NEED

C(I).1. DESCRIBE THE RELATIONSHIP OF THIS PROPOSAL TO THE IMPLEMENTATION OF THE STATE HEALTH PLAN AND TENNESSEE'S HEALTH: GUIDELINES FOR GROWTH.

A. PLEASE PROVIDE A RESPONSE TO EACH CRITERION AND STANDARD IN CON CATEGORIES THAT ARE APPLICABLE TO THE PROPOSED PROJECT. DO NOT PROVIDE RESPONSES TO GENERAL CRITERIA AND STANDARDS (PAGES 6-9) HERE.

B. APPLICATIONS THAT INCLUDE A CHANGE OF SITE FOR A HEALTH CARE INSTITUTION, PROVIDE A RESPONSE TO GENERAL CRITERION AND STANDARDS (4)(a-c).

Project-Specific Review Criteria: Ambulatory Surgical Treatment Centers (2012 State Health Plan)

Assumptions in Determination of Need

The need for an ambulatory surgical treatment center shall be based upon the following assumptions:

1. Operating Rooms

a. An operating room is available 250 days per year, 8 hours per day.
b. The estimated average time per Case in an Operating Room is 65 minutes.
c. The average time for clean up and preparation between Operating Room Cases is 30 minutes.
d. The optimum utilization of a dedicated, outpatient, general-purpose Operating Room is 70% of full capacity. 70% x 250 days/year x 8 hours/day divided by 95 minutes = 884 Cases per year.

Criteria 1a-1d above are not applicable. The facility will not have any Operating Rooms; it will have only Procedure Rooms.

2. Procedure Rooms

a. A procedure room is available 250 days per year, 8 hours per day.

Complies. The Endoscopy Center will be operated from 7 am to 4 pm Monday through Friday, 50 weeks per year.

b. The estimated average time per outpatient Case in a procedure room is 30 minutes.

Complies. The average time per case (excluding room turnaround) is projected to be 25 minutes.

c. The average time for clean up and preparation between Procedure Room Cases is 15 minutes.

Complies. The average time allowed for room turnaround between endoscopy cases is projected to be 10 minutes.

d. The optimum utilization of a dedicated, outpatient, general-purpose outpatient Procedure Room is 70% of full capacity. 70% x 250 days/year x 8 hours/day divided by 45 minutes = 1867 Cases per year.

Complies. In Year Two (CY 2018), the facility's projected utilization of 12,981 cases demonstrates a need for 7 procedure rooms at the optimal standard (12,981 / 1,867 = 7.0 rooms). Only 6 rooms are proposed in the project.

Determination of Need
1. Need. The minimum numbers of 884 Cases per Operating Room and 1867 Cases per Procedure Room are to be considered as baseline numbers for purposes of determining Need. An applicant should demonstrate the ability to perform a minimum of 884 Cases per Operating Room and/or 1867 Cases per Procedure Room per year, except that an applicant may provide information on its projected case types and its assumptions of estimated average time and clean up and preparation time per Case if this information differs significantly from the above-stated assumptions. It is recognized that an ASTC may provide a variety of services/Cases and that as a result the estimated average time and clean up and preparation time for such services/Cases may not meet the minimum numbers set forth herein. It is also recognized that an applicant applying for an ASTC Operating Room(s) may apply for a Procedure Room, although the anticipated utilization of that Procedure Room may not meet the base guidelines contained here. Specific reasoning and explanation for the inclusion in a CON application of such a Procedure Room must be provided. An applicant that desires to limit its Cases to a specific type or types should apply for a Specialty ASTC.

See Criterion 2d above. In Year Two of its operation, the replacement facility will average 2,164 cases per room, with 6 rooms. The applicant does not require exceptions to the criterion.

2. Need and Economic Efficiencies. An applicant must estimate the projected surgical hours to be utilized per year for two years based on the types of surgeries to be performed, including the preparation time between surgeries. Detailed support for estimates must be provided.

The following estimates are based on AmSurg's extensive experience operating and managing this type of facility. AmSurg operates the nation's largest system of endoscopy centers. These case times could vary, depending on the mix of low and high acuity cases.

Year One (12,852 cases)

a. Average surgical time for endoscopy case: 25 minutes

b. Average room turnaround time: 10 minutes

c. Total average minutes per case: **35 minutes**

d. Available time in 6 procedure rooms:

60 minutes per hour X 8 hours per day X 250 days per year X 6 procedure rooms = 720,000 minutes of surgical room time available per year

e. Time required to perform Year Two projected volume of 12,852 cases:

12,852 cases X 35 total average minutes per case = 449,820 minutes required per year

f. Utilization or Occupancy Rate of Procedure Rooms =

449,820 minutes utilized / 720,000 minutes available **=62.5% average utilization**

Year Two (12,981 cases)

a. Average surgical time for endoscopy case: 25 minutes

b. Average room turnaround time: 10 minutes

c. Total average minutes per case: **35 minutes**

d. Available time in 6 procedure rooms:

60 minutes per hour X 8 hours per day X 250 days per year X 6 procedure rooms = 720,000 minutes of surgical room time available per year

e. Time required to perform Year One projected volume of 12,981 cases:

12,981 X 35 total average minutes per case = 454,335 minutes required per year

f. Utilization or Occupancy Rate of Procedure Rooms =

454,335 minutes utilized / 720,000 minutes available = **63.1% average utilization**

3. Need; Economic Efficiencies; Access. To determine current utilization and need, an applicant should take into account both the availability and utilization of either: a) all existing outpatient Operating Rooms and Procedure Rooms in a Service Area, including physician office based surgery rooms (when those data are officially reported and available) OR b) all existing comparable outpatient Operating Rooms and Procedure Rooms based on the type of Cases to be performed. Additionally, applications should provide similar information on the availability of nearby out-of-state existing outpatient Operating Rooms and Procedure Rooms, if that data are available, and provide the source of that data. Unstaffed dedicated outpatient Operating Rooms and unstaffed dedicated outpatient Procedure Rooms are considered available for ambulatory surgery and are to be included in the inventory and in the measure of capacity.

In Sections B.II.C. above and C(I)5-6 below, the applicant has presented the publicly available data on utilization of 7 area providers that perform endoscopies (i.e., excluding eye surgery centers, plastic surgery centers, etc. which do not have gastroenterologists on staff; and excluding hospitals which do not report endoscopy cases.) In FYE 2014, the service area facilities that reported endoscopy utilization any year between FYE 2012 and FYE 2014 averaged 1,865 cases per procedure room--approximately the State Health Plan's optimal level of areawide utilization (1,867 per room). And by reducing the area's total procedure rooms, the project will increase average utilization per room, compared to what it would be if this project does not occur.

4. Need and Economic Efficiencies. An applicant must document the potential impact that the proposed new ASTC would have upon the existing service providers and their referral patterns. A CON application to establish an ASTC or to expand existing services of an ASTC should not be approved unless the existing ambulatory surgical services that provide comparable services regarding the types of Cases performed, if those services are know and relevant, within the applicant's proposed Service Area or within the applicant's facility are demonstrated to be currently utilized at 70% or above.

Not applicable. The project does not establish a facility; it only relocates an existing facility. It does not expand the facility in terms of its surgical services. The data provided in Section C(I)5-6 show that area facilities in FYE 2014 were utilized at 1,865 cases per procedure room, which for practical purposes equals the 70% criterion (1,867).

5. Need and Economic Efficiencies. An application for a Specialty ASTC should present its projections for the total number of cases based on its own calculations for the projected length of time per type of case, and shall provide any local, regional, or national data in support of its methodology. An applicant for a Specialty ASTC should provide its own definitions of the surgeries and/or procedures that will be performed and whether the Surgical Cases will be performed in an Operating Room or a Procedure Room. An applicant for a Specialty ASTC must document the potential impact that the proposed new ASTC would have upon the existing service providers and their referral patterns. A CON proposal to establish a Specialty ASTC or to expand existing services of a Specialty ASTC shall not be approved unless the existing ambulatory surgical services that provide comparable services regarding the types of Cases performed within the applicant's proposed Service Area or within the applicant's facility are demonstrated to be currently utilized at 70% or above. An applicant that is granted a CON for a Specialty ASTC shall have the specialty or limitation placed on the CON.

The applicant will perform only outpatient gastroenterology cases, to which it is currently limited. No change in that limitation is being requested. The applicant will perform these cases solely in procedure rooms. No operating rooms are available at the current location and none will be available at the new location. The other information requested in criterion #5 duplicates information already provided in response to criteria #2 and #4. Please see the applicant's responses to those criteria with respect to:

- Case time analysis based on applicant's own experience;
- Impact on other area facilities;
- Utilization data from other comparable facilities in the primary service area.

See also Section C(I)5 below for utilization of comparable facilities in the service area.

Other Standards and Criteria

6. Access to ASTCs. The majority of the population in a Service Area should reside within 60 minutes average driving time to the facility.

Complies. See drive time tables in Section B.III.B.1 above. The average drive time from major population centers in the service area is approximately 30 minutes.

7. Access to ASTCs. An applicant should provide information regarding the relationship of an existing or proposed ASTC site to public transportation routes if that information is available.

There is bus service available to the site. A Knoxville Area Transit (KAT) bus route map has been provided in Attachment C, Need--3.

8. Access to ASTCs. An application to establish an ambulatory surgical treatment center or to expand existing services of an ambulatory surgical treatment center must
- **project the origin of potential patients by percentage and county of residence and, if such data are readily available, by zip code, and**
- **must note where they are currently being served.**
- **Demographics of the Service Area should be included, including the anticipated provision of services to out-of-state patients, as well as**
- **the identity of other service providers both in and out of state and the source of out-of-state data. Applicants shall document all other provider alternatives available in the Service Area.**
- **All assumptions, including the specific methodology by which utilization is projected, must be clearly stated.**

Patient Origin: This is provided in Sections C(I)3-4. The primary service area will consist of Knox, Sevier, Jefferson, Blount, Anderson, and Hamblen Counties in East Tennessee. Zip code patient origin is not readily available.

Places of Current Service: The applicant does not project any significant negative impact on other facilities. The projected caseload at the new location is below what this facility experienced as recently as 2013, when Federal rules requiring ASTC's not to share space with physician practices compelled the facility to change to morning-only operation.

Demographics of the Service Area: This is provided in Section C(I)4.A.

Service Area Providers: The Tennessee Joint Annual Reports ("JARs") for Hospitals do not their number of endoscopies, or the endoscopies performed in the hospital's OR's vs. procedure rooms. The JAR's for Ambulatory Surgical Treatment Centers do state their numbers of endoscopy patients--but until FYE 2013 they did not report the utilization of total cases by OR's vs. procedure rooms. So unless the reporting facility is a single-specialty endoscopic surgery center, it is not possible to identify the procedure room utilization for just endoscopies. It is possible to identify procedure room utilization for all cases. The applicant has provided all available utilization data for all area surgery centers reporting endoscopy cases in Section C(I)5 below.

Assumptions--Each section's responses identifies its assumptions and sources of data.

9. Access and Economic Efficiencies. An application to establish an ambulatory surgical treatment center or to expand existing services of an ambulatory surgical treatment center must project patient utilization for each of the first eight quarters following completion of
the project. All assumptions, including the specific methodology by which utilization is projected, must be clearly stated.

Please see Section C(I)6 in the application. Quarterly breakdowns were distributed approximately evenly.

Table Five: The Endoscopy Center
Projection of Quarterly Cases, Years One and Two

	Q1 Cases	Q2 Cases	Q3 Cases	Q4 Cases	Total
2017	3,213	3,213	3,213	3,213	12,852
2018	3,245	3,245	3,245	3,246	12,981

10. Patient Safety and Quality of Care; Health Care Workforce.

a. An applicant should be or agree to become accredited by any accrediting organization approved by the Centers for Medicare and Medicaid Services, such as the Joint Commission, the Accreditation Association of Ambulatory Health Care, the American Association for Accreditation of Ambulatory Surgical Facilities, or other nationally recognized accrediting organization.

The applicant is already AAAHC-accredited and is committed to maintaining its accreditation.

b. An applicant should estimate the number of physicians by specialty that are

expected to utilize the facility and the criteria to be used by the facility in extending surgical and anesthesia privileges to medical personnel. An applicant should provide documentation on the availability of appropriate and qualified staff that will provide ancillary support services, whether on- or off-site.

The medical staff consists of 12 (soon to be 13) gastroenterologists. Their Board status is provided in Attachment C-Need--1.A.3. The facility requires that physicians applying for surgical or anesthesia privileges be Board-certified or Board-eligible in their appropriate specialties, along with other customary criteria.

11. Access to ASTCs. In light of Rule 0720-11.01, which lists the factors concerning need on which an application may be evaluated, and Principle No. 2 in the State Health Plan, *"Every citizen should have reasonable access to health care,"* the HSDA may decide to give special consideration to an applicant:
a. Who is offering the service in a medically underserved area as designated by the United States Health Resources and Services Administration;

The primary service area consists of Knox, Sevier, Jefferson, Blount, Anderson, and Hamblen Counties. Parts of this area are designated as medically underserved areas. They are identified in Attachment C-Need-1.A.

b. Who is a "safety net hospital" or a "children's hospital" as defined by the Bureau of TennCare Essential Access Hospital payment program;

Not applicable.

c. Who provides a written commitment of intention to contract with at least one TennCare MCO and, if providing adult services, to participate in the Medicare program;

The applicant so commits. The applicant already contracts with Medicare, and with three of the four TennCare MCO's in the area. The applicant is awaiting acceptance of a contract by the fourth MCO.

d. Who is proposing to use the ASTC for patients that typically require longer preparation and scanning times. The applicant shall provide in its application information supporting the additional time required per Case and the impact on the need standard.

Not applicable. The applicant's case times are not longer than the criteria.

Project-Specific Review Criteria: Construction, Renovation, Expansion, and Replacement of Health Care Institutions

1. Any project that includes the addition of beds, services, or medical equipment will be reviewed under the standards for those specific activities.

Not applicable; none of these changes is being proposed.

2. For relocation or replacement of an existing licensed healthcare institution:

a. The applicant should provide plans which include costs for both renovation and relocation, demonstrating the strengths and weaknesses of each alternative.

The applicant has provided detailed cost projections for relocation to a new site. Providing plans and budgets for "renovation" is not possible because the facility's current location is merged with a private group medical practice and there is no space into which the ASTC can expand by renovation to provide appropriate pre-op, recovery, and other support spaces.

b. The applicant should demonstrate that there is an acceptable existing or projected future demand for the proposed project.

This is an existing facility. Its FYE 2013 utilization was reduced by 26% in CY2015 by having to cease operation as an ASTC in the afternoons. The cases projected for the first two years of this project are still below what these physicians received as referrals in 2013 when they had capacity in the ASTC to accept those referrals.

3. For renovation or expansion of an existing licensed healthcare institution:

a. The applicant should demonstrate that there is an acceptable existing demand for the proposed project.

b. the applicant should demonstrate that the existing physical plant's condition warrants major renovation or expansion.

Not applicable; this is a replacement project and not a renovation or expansion project.

The Framework for Tennessee's Comprehensive State Health Plan

Five Principles for Achieving Better Health

The following Five Principles for Achieving Better Health serve as the basic framework for the State Health Plan. After each principle, the applicant states how this CON application supports the principle, if applicable.

1. Healthy Lives

The purpose of the State Health Plan is to improve the health of Tennesseans. **Every person's health is the result of the interaction of individual behaviors, society, the environment, economic factors, and our genetic endowment. The State Health Plan serves to facilitate the collaboration of organizations and their ideas to help address health at these many levels.**

The project represents the collaboration of a major gastroenterology group practice with the nation's largest operator of endoscopic ambulatory surgical treatment centers, pairing medical expertise with management skills to foster continuous quality improvement and significant cost controls.

2. Access to Care

Every citizen should have reasonable access to health care.
Many elements impact one's access to health care, including existing health status, employment, income, geography, and culture. The State Health Plan can provide standards for reasonable access, offer policy direction to improve access, and serve a coordinating role to expand health care access.

The project pays careful attention to accessibility, both from financial and physical perspectives. The applicant has contracts with three of the four TennCare MCO's now operating Statewide; and is seeking a contract with the fourth MCO. The proposed site is very physically accessible to the service area counties in terms of drive time.

3. Economic Efficiencies

The state's health care resources should be developed to address the needs of Tennesseans while encouraging competitive markets, economic efficiencies and the continued development of the state's health care system. **The State Health Plan should work to identify opportunities to improve the efficiency of the state's health care system and to encourage innovation and competition.**

The project will provide an efficient facility for the delivery of care, one which conforms to current codes and design standards. This will be done in a setting that costs Medicare approximately 30%-40% less than if the same surgeries were performed in a hospital or in a hospital-based outpatient department.

4. Quality of Care

Every citizen should have confidence that the quality of health care is continually monitored and standards are adhered to by health care providers. **Health care providers are held to certain professional standards by the state's licensure system. Many health care stakeholders are working to improve their quality of care through adoption of best practices and data-driven evaluation.**

AmSurg Corp and the physician members of the applicant L.P. are committed to processes of continuous quality improvement and the delivery of cost-effective "best practices" medical care.

5. Health Care Workforce

The state should support the development, recruitment, and retention of a sufficient and quality health care workforce. **The state should consider developing a comprehensive approach to ensure the existence of a sufficient, qualified health care workforce, taking into account issues regarding the number of providers at all levels and in all specialty and focus areas, the number of professionals in teaching positions, the capacity of medical, nursing, allied health and other educational institutions, state and federal laws and regulations impacting capacity programs, and funding.**

The project has no significant impact on the healthcare workforce.

C(I).2. DESCRIBE THE RELATIONSHIP OF THIS PROJECT TO THE APPLICANT'S LONG-RANGE DEVELOPMENT PLANS, IF ANY.

The Endoscopy Center (Knoxville) does not prepare long-range development plans.

C(I).3. IDENTIFY THE PROPOSED SERVICE AREA AND JUSTIFY THE REASONABLENESS OF THAT PROPOSED AREA. SUBMIT A COUNTY-LEVEL MAP INCLUDING THE STATE OF TENNESSEE CLEARLY MARKED TO REFLECT THE SERVICE AREA. PLEASE SUBMIT THE MAP ON A 8-1/2" X 11" SHEET OF WHITE PAPER MARKED ONLY WITH INK DETECTABLE BY A STANDARD PHOTOCOPIER (I.E., NO HIGHLIGHTERS, PENCILS, ETC.).

This is an existing facility whose relocation 1.4 miles away in the same city should not affect its patient origin. Table Six on the next page shows its patient origin by county and projects a similar patient origin for the relocated facility. The primary service area counties, from which approximately 82.1% of its patients came in CY2014, consisted of Knox, Sevier, Jefferson, Blount, Anderson, and Hamblen Counties. The projected origin of cases in CY 2017 and CY2018 should be the same.

Location maps and a map of the service area are provided in the Attachments to the application.

Table Six: The Endoscopy Center (Knoxville) Patient Origin Projection CY2017-18					
County	Patients CY2014	Percent of Total Patients	Cumulative Percent of Total Patients	Year One CY2017 Cases	Year Two CY2018 Cases
Primary Service Area (PSA) Counties					
Knox	5,190	61.8%	61.8%	7,939	8,018
Sevier	544	6.5%	68.2%	832	840
Jefferson	404	4.8%	73.1%	618	624
Blount	295	3.5%	76.6%	451	456
Anderson	244	2.9%	79.5%	373	377
Hamblen	222	2.6%	82.1%	340	343
PSA Subtotal	*6,899*	*82.1%*			
Secondary Service Area (SSA) Counties and States	*1,503*	*17.9%*		*2,299*	*2,322*
Grand Total	*8,402*	*100.0%*		*12,852*	*12,981*

Source: Medical staff patient origin records and management projections.

C(I).4.A DESCRIBE THE DEMOGRAPHICS OF THE POPULATION TO BE SERVED BY THIS PROPOSAL.

Table Seven on the next page provides the Tennessee Department of Health's projections that this service area's total population will increase by 4.6% from 2015 to 2019. This will be faster than the 32.7% rate of increase projected Statewide.

The population 50+ years of age is the cohort that most highly utilizes endoscopy services. That cohort in the service area is projected to increase 8.6% compared to a Statewide increase of 6.1%.

Median income in the primary service area is slightly less than Statewide. TennCare enrollment is lower at 17.8% than for the State as a whole, which is 21.0%. Approximately 16.4% of service area residents have annual incomes below the Federal poverty level, compared to 17.6% Statewide.

Table Seven: The Endoscopy Center (Knoxville)
Demographic Characteristics of Primary Service Area
2015-2019

Primary Service Area	Demographic Characteristics													
County	Median Age - 2010 Census	Total Population 2015	Total Population 2019	Total Population % Change 2015 - 2019	Total Population Age 50+ 2015	% of Population	Total Population Age 50+ 2019	% of Population	Age 50+ Population - Change 2015 - 2019	Median Household Income	TennCare Enrollees Apr 2015	Percent of 2015 Population Enrolled in TennCare	Persons Below Poverty Level	Persons Below Poverty Level as % of Population US Census
Anderson	42.6	76,949	78,123	1.5%	32,906	42.8%	34,458	44.1%	4.7%	$43,620	15,946	20.7%	5,989	18.2%
Blount	41.4	129,973	137,058	5.5%	51,476	39.6%	55,032	40.2%	6.9%	$45,991	21,570	16.6%	7,052	13.7%
Hamblen	39.6	64,438	65,952	2.3%	23,925	37.1%	24,766	37.6%	3.5%	$39,596	15,217	23.6%	4,594	19.2%
Jefferson	40.8	54,482	57,707	5.9%	21,466	39.4%	23,096	40.0%	7.6%	$39,745	11,841	21.7%	3,928	18.3%
Knox	37.2	459,124	481,044	4.8%	164,888	35.9%	183,248	38.1%	11.1%	$47,694	73,127	15.9%	24,074	14.6%
Sevier	40.9	96,116	101,929	6.0%	37,704	39.2%	40,422	39.7%	7.2%	$43,649	18,970	19.7%	5,467	14.5%
Tennessee PSA	40.4	881,082	921,813	4.6%	332,365	37.7%	361,022	39.2%	8.6%	$43,383	156,671	17.8%	51,104	16.4%
State of Tennessee	38.0	6,649,438	6,894,997	3.7%	2,346,357	35.3%	2,490,254	36.1%	6.1%	$44,298	1,399,004	21.0%	1,170,301	17.6%

Sources: TDH Population Projections, May 2013; U.S. Census QuickFacts; TennCare Bureau Apr 2015.
PSA data is unweighted average, or total, of county data.

C(I).4.B. DESCRIBE THE SPECIAL NEEDS OF THE SERVICE AREA POPULATION, INCLUDING HEALTH DISPARITIES, THE ACCESSIBILITY TO CONSUMERS, PARTICULARLY THE ELDERLY, WOMEN, RACIAL AND ETHNIC MINORITIES, AND LOW-INCOME GROUPS. DOCUMENT HOW THE BUSINESS PLANS OF THE FACILITY WILL TAKE INTO CONSIDERATION THE SPECIAL NEEDS OF THE SERVICE AREA POPULATION.

The need for periodic screening and other endoscopies is now considered universal for all persons 50 years of age and older (45 years of age or older for African-Americans), in order to prevent avoidable deaths from colon cancer. This is a need shared by all, regardless of gender, race, ethnicity, or income level.

The Endoscopy Center is open to all of the above groups. It contracts with three of Tennessee's TennCare plans, and will be contracted to a fourth plan in the near future. For persons without adequate insurance, discounting and periodic payment plans are worked out individually prior to service, with eligibility based on income. Charitable discounts were calculated for the Historic and Projected Data Charts in this application.

C(I).5. DESCRIBE THE EXISTING OR CERTIFIED SERVICES, INCLUDING APPROVED BUT UNIMPLEMENTED CON'S, OF SIMILAR INSTITUTIONS IN THE SERVICE AREA. INCLUDE UTILIZATION AND/OR OCCUPANCY TRENDS FOR EACH OF THE MOST RECENT THREE YEARS OF DATA AVAILABLE FOR THIS TYPE OF PROJECT. BE CERTAIN TO LIST EACH INSTITUTION AND ITS UTILIZATION AND/OR OCCUPANCY INDIVIDUALLY. INPATIENT BED PROJECTS MUST INCLUDE THE FOLLOWING DATA: ADMISSIONS OR DISCHARGES, PATIENT DAYS, AND OCCUPANCY. OTHER PROJECTS SHOULD USE THE MOST APPROPRIATE MEASURES, E.G., CASES, PROCEDURES, VISITS, ADMISSIONS, ETC.

In the project's primary service area, there are 7 ambulatory surgical treatment centers whose Joint Annual Reports indicate that they performed outpatient endoscopies during one or more of the past three reporting years (FYE's ending June 30). Their utilization for those years is shown in Table Eight-A on the following page. Table Eight-B on the second following page shows these providers' cases by procedure room and operating room, for FYE 2013-14, the only two years for which such JAR data is available. Utilization per procedure room increased 8.2% from FYE 2013 to FYE 2014.

Table Eight-A: The Endoscopy Center (Knoxville)
Primary Service Area Utilization of Ambulatory Surgical Treatment Centers Performing Endoscopies

	2012 Joint Annual Report of ASTC's							
County	Facility Name	O.R.'s	Procedure Rooms	Total Surgical Rooms	Total Cases	Cases Per Surgical Room	GI Endoscopy Cases	GI Endoscopy Cases Percent of Total Cases
Knox	Children's West Surgery Center	3	0	3	3,900	1,300	165	4.2%
	Fort Sanders West Surgery Center	4	0	4	1,616	404	0	0.0%
	Parkwest Surgery Center	5	1	6	4,681	780	0	0.0%
	The Endoscopy Center	0	8	8	9,421	1,178	9,421	100.0%
	The Endoscopy Center North	0	2	2	4,116	2,058	4,116	100.0%
	The Endoscopy Center West	0	2	2	2,945	1,473	2,945	100.0%
Blount	Tennessee Endoscopy Center	0	3	3	5,543	1,848	5,543	100.0%
	PRIMARY SERVICE AREA	12	16	28	32,222	1,151	22,190	68.9%
	2013 Joint Annual Report of ASTC's							
County	Facility Name	O.R.'s	Procedure Rooms	Total Surgical Rooms	Total Cases	Cases Per Surgical Room	GI Endoscopy Cases	GI Endoscopy Cases Percent of Total Cases
Knox	Children's West Surgery Center	3	0	3	4,125	1,375	172	4.2%
	Fort Sanders West Surgery Center	4	0	4	3,523	881	0	0.0%
	Parkwest Surgery Center	5	1	6	4,775	796	0	0.0%
	The Endoscopy Center	0	8	8	11,788	1,474	11,788	100.0%
	The Endoscopy Center North	0	2	2	4,816	2,408	4,816	100.0%
	The Endoscopy Center West	0	2	2	3,749	1,875	3,749	100.0%
Blount	Tennessee Endoscopy Center	0	3	3	7,012	2,337	7,012	100.0%
	PRIMARY SERVICE AREA	12	16	28	39,788	1,421	27,537	69.2%
	2014 Joint Annual Report of ASTC's							
County	Facility Name	O.R.'s	Procedure Rooms	Total Surgical Rooms	Total Cases	Cases Per Surgical Room	GI Endoscopy Cases	GI Endoscopy Cases Percent of Total Cases
Knox	Children's West Surgery Center	3	0	3	4,569	1,523	184	4.0%
	Fort Sanders West Surgery Center	4	0	4	2,003	501	137	6.8%
	Parkwest Surgery Center	5	1	6	5,343	891	0	0.0%
	The Endoscopy Center	0	8	8	9,953	1,244	9,953	100.0%
	The Endoscopy Center North	0	2	2	6,237	3,119	6,237	100.0%
	The Endoscopy Center West	0	2	2	4,929	2,465	4,929	100.0%
Blount	Tennessee Endoscopy Center	0	3	3	7,081	2,360	7,012	99.0%
	PRIMARY SERVICE AREA	12	16	28	40,115	1,433	28,452	70.9%

Source: Joint Annual Reports, FYE 2012-2014.

Table Eight-B:
FYE 2013-2014 Utilization of Endoscopy ASTC Providers By Type of Room
(Unavailable in the Joint Annual Report Before FYE 2013)

FYE 2014
ASTC'S Performing Endoscopies in Project's Primary Service Area

			FY Cases in Operating Rooms		FY Cases in Procedure Rooms	
ASTC Name	OR's	Procedure Rooms	FY Cases	FY Cases Per OR	FY Cases	FY Cases Per Room
KNOX COUNTY						
Children's West Surg. Cntr.	3	0	4,569	1,523	0	0
Ft .Sanders W. Surg. Center	4	0	2,003	501	0	0
Parkwest Surgery Center	5	1	3,704	741	1,639	1,639
The Endoscopy Center	0	8	0	0	9,953	1,244
The Endoscopy Center N.	0	2	0	0	6,237	3,119
The Endoscopy Center W.	0	2	0	0	4,929	2,465
BLOUNT COUNTY						
Tennessee Endoscopy Cntr.	0	3	0	0	7,081	2,360
Service Area Totals	**12**	**16**	**10,276**	**856**	**29,839**	**1,865**

FYE 2013
ASTC'S Performing Endoscopies in Project's Primary Service Area

			FY Cases in Operating Rooms		FY Cases in Procedure Rooms	
ASTC Name	OR's	Procedure Rooms	FY Cases	FY Cases Per OR	FY Cases	FY Cases Per Room
KNOX COUNTY						
Children's West Surg. Cntr.	3	0	4,125	1,375	0	0
Ft .Sanders W. Surg. Center	4	0	3,523	881	0	0
Parkwest Surgery Center	5	1	3,960	792	815	815
The Endoscopy Center	0	8	0	0	11,788	1,250
The Endoscopy Center N.	0	2	0	0	4,816	2,120
The Endoscopy Center W.	0	2	0	0	3,749	634
BLOUNT COUNTY						
Tennessee Endoscopy Cntr.	0	3	0	0	7,012	2,337
Service Area Totals	**12**	**16**	**11,608**	**967**	**27,565**	**1,723**

Source: Joint Annual Reports page 7 Schedule D, as amended by applicant 7-15.

C(I).6. PROVIDE APPLICABLE UTILIZATION AND/OR OCCUPANCY STATISTICS FOR YOUR INSTITUTION FOR EACH OF THE PAST THREE (3) YEARS AND THE PROJECTED ANNUAL UTILIZATION FOR EACH OF THE TWO (2) YEARS FOLLOWING COMPLETION OF THE PROJECT. ADDITIONALLY, PROVIDE THE DETAILS REGARDING THE METHODOLOGY USED TO PROJECT UTILIZATION. THE METHODOLOGY MUST INCLUDE DETAILED CALCULATIONS OR DOCUMENTATION FROM REFERRAL SOURCES, AND IDENTIFICATION OF ALL ASSUMPTIONS.

The historical and projected utilization for The Endoscopy Center (Knoxville) is shown in Table Three-A below.

Historically, The Endoscopy Center on Weisgbarber Road in Knoxville was one of the earliest endoscopic ambulatory surgery centers developed in Tennessee. It opened in 1986, almost three decades ago. It was also the Knoxville region's largest ASTC provider of outpatient endoscopic cases until July of 2013. In the fiscal year ending June 2013, of the seven area ASTC's who performed endoscopic cases, The Endoscopy Center performed almost 30% of all those cases and performed 64% more cases than the next-highest provider.

Between 2010 and 2013, Medicare directed surgery centers nationwide to cease all space-sharing arrangements with adjoining physician practice offices. Up to that time, it was commonplace--and very economical--for surgery centers to share areas such as reception, waiting, and business with the physician group practices that constituted their medical staffs. The Endoscopy Center shared some spaces with its associated medical practice, Gastrointestinal Associates ("GIA").

Threatened with loss of Medicare reimbursement, but with no expansion room available in its Weisgarber Road building, and with lease commitments, The Endoscopy Center's only way to comply with Medicare's new space-sharing prohibition was to negotiate a temporary time-sharing agreement with the medical practice (GIA), that was acceptable to Medicare and to State Licensure. The agreement gave the Center exclusive use of the entire premises from 7 AM to noon daily, with GIA using the entire premises exclusively as a gastroenterology group practice office during the afternoons. This operational arrangement is still in effect.

The sudden reduction of *effective* surgical capacity by a required closure at noon, and the death of the center's busiest surgeon (who performed approximately 1,500 cases per year), caused the center's utilization to decline the following year by 15%--from 11,251 cases in CY2013 to a projected 9,560 cases in CY2015. With additional physician recruitment since 2013, utilization is slowly increasing, but the limitation to half-day operation is a severe restraint on case referrals to this practice and to its ASTC.

The facility's annualized CY2015 utilization based on January-June is 9,560 cases. In CY2016, at the current location, facility management projects that normal growth in physician referrals will increase utilization by at least 1%, to 9,656 cases. In CY2017, even at the current location, normal growth brought by existing medical staff will again increase utilization by 1%, to 9,752 cases.

But if the proposed relocation is approved, allowing normal full-day operation, an *additional* 3,100 new cases will be brought to the new location in CY2017 by two physicians who currently do not have room to perform their cases at this facility. Dr. Jeff Gilbert, an established Anderson County gastroenterologist, is joining the Center in late 2015. He projects bringing 2,200 of his current cases to the new location in CY2017. Dr. Matthew Moore will bring 900 cases--600 cases currently being performed at two Knox County endoscopy centers owned by this same applicant, plus 300 new cases from normal practice growth between 2015 and 2017. Dr. Gilbert's and Dr. Moore's letter attesting to these new cases are provided in the Attachments.

In CY2017, with a normal full-day surgical schedule resumed at the new location, and with Dr. Gilbert and Dr. Moore's transferred cases, The Endoscopy Center projects a first-year caseload of 12,852 cases. The following year the Center projects a continuing 1% increase in utilization, to 12,981 cases.

Table Three-A below shows that the projected occupancy on the proposed facility is consistent with the Guidelines of the State Health Plan. The Table shows surgical room utilization as a percent of three standards: (a) Amsurg's broad general goal of performing 2,500 cases per room; (b) the State Health Plan's "optimal" goal of 1,867

cases per room (70% occupancy); and (c) the State Health Plan's definition of 100% occupancy for a procedure room.

The project will operate in Year Two (2018) at approximately 116% of the State Health Plan's optimal efficiency standard. It will operate at 86.6% of AmSurg's own higher expectation for this type of facility.

Table Three-A: The Endoscopy Center (Knoxville)
Historical and Projected Utilization 2012-2018 (Year Two)
Patients/Cases

Calendar Year	Procedure Rooms	Cases	Cases Per Room	Percent of AmSurg Optimal Cases of 2,500 / Rm	Percent of State Health Plan Optimal Cases of 1,867 / Rm	Percent of State Health Plan Full Capacity Cases of 2,667 / Rm
(Historical)						
CY 2012	8	11,462	1,433	57.3%	76.8%	53.7%
CY 2013	8	11,251	1,406	56.2%	75.3%	52.7%
CY 2014	8	9,652	1,207	48.3%	64.6%	45.3%
(Projected)						
CY 2015	8	9,560	1,195	47.8%	64.0%	44.8%
CY 2016	8	9,656	1,207	48.3%	64.7%	45.3%
CY 2017-Yr 1	**6**	**12,852**	**2,142**	**85.7%**	**114.7%**	**80.3%**
CY 2018-Yr 2	**6**	**12,981**	**2,164**	**86.6%**	**115.9%**	**81.1%**

Sources: FY2012-15 historical cases from AmSurg management and facility records; 2015 annualized on Jan-June. CY2016-18 projected cases from AmSurg management.

Converting this utilization into room need, Table Three-B below shows the procedure rooms that the projected utilization needs under AmSurg's and the State Health Plan's standards. Under the State Health Plan's optimal occupancy standard, seven procedure rooms will be needed in CY2018, Year Two. AmSurg's standard indicates that with a need for 5.2 procedure rooms, 6 rooms will be appropriate and will provide room for future growth. Consistent with that, 6 rooms are being proposed in this application. That will be a decrease of 2 rooms from the current 8-room license.

Table Three-B: The Endoscopy Center (Knoxville) Procedure Room Need Based on AmSurg and State Health Plan Utilization Standards					
Year	**Procedure Rooms**	**Cases**	**Cases Per Room**	**Room Need At AmSurg Goal of 2500 Cases Per Room**	**Room Need At State Health Plan Optimal Standard of 1,867 Cases Per Room**
(Historical)					
CY 2012	8	11,462	1,433	4.6	6.1
CY 2013	8	11,251	1,406	4.5	6.0
CY2014	8	9,652	1,207	3.9	5.2
(Projected)					
CY 2015 Ann'd	8	9,560	1,195	3.8	5.1
CY 2016	8	9,656	1,207	3.9	5.2
CY 2017-Yr 1	**6**	**12,852**	**2,142**	**5.1**	**6.9**
CY 2018-Yr 2	**6**	**12,981**	**2,164**	**5.2**	**7.0**

Source: Table Three-A.

C(II)1. PROVIDE THE COST OF THE PROJECT BY COMPLETING THE PROJECT COSTS CHART ON THE FOLLOWING PAGE. JUSTIFY THE COST OF THE PROJECT.

• ALL PROJECTS SHOULD HAVE A PROJECT COST OF AT LEAST $3,000 ON LINE F (MINIMUM CON FILING FEE). CON FILING FEE SHOULD BE CALCULATED ON LINE D.

• THE COST OF ANY LEASE (BUILDING, LAND, AND/OR EQUIPMENT) SHOULD BE BASED ON FAIR MARKET VALUE OR THE TOTAL AMOUNT OF THE LEASE PAYMENTS OVER THE INITIAL TERM OF THE LEASE, WHICHEVER IS GREATER. NOTE: THIS APPLIES TO ALL EQUIPMENT LEASES INCLUDING BY PROCEDURE OR "PER CLICK" ARRANGEMENTS. THE METHODOLOGY USED TO DETERMINE THE TOTAL LEASE COST FOR A "PER CLICK" ARRANGEMENT MUST INCLUDE, AT A MINIMUM, THE PROJECTED PROCEDURES, THE "PER CLICK" RATE AND THE TERM OF THE LEASE.

• THE COST FOR FIXED AND MOVEABLE EQUIPMENT INCLUDES, BUT IS NOT NECESSARILY LIMITED TO, MAINTENANCE AGREEMENTS COVERING THE EXPECTED USEFUL LIFE OF THE EQUIPMENT; FEDERAL, STATE, AND LOCAL TAXES AND OTHER GOVERNMENT ASSESSMENTS; AND INSTALLATION CHARGES, EXCLUDING CAPITAL EXPENDITURES FOR PHYSICAL PLANT RENOVATION OR IN-WALL SHIELDING, WHICH SHOULD BE INCLUDED UNDER CONSTRUCTION COSTS OR INCORPORATED IN A FACILITY LEASE.

• FOR PROJECTS THAT INCLUDE NEW CONSTRUCTION, MODIFICATION, AND/OR RENOVATION; DOCUMENTATION MUST BE PROVIDED FROM A CONTRACTOR AND/OR ARCHITECT THAT SUPPORT THE ESTIMATED CONSTRUCTION COSTS.

The architect's letter supporting the construction cost estimate is provided in Attachment C, Economic Feasibility--1.

On the Project Costs Chart, following this response:

Line A.1, A&E fees, were estimated by the project architect.

Line A.2, legal, administrative, and consultant fees, include a contingency for expenses of legal counsel in the event of opposition.

Line A.5, construction cost, was calculated by AmSurg development staff. Please note that this is the build-out cost for the CON applicant, in leased space. It does not include the developer's building cost, which is taken into account in the Chart under Section B.1 (see below for explanation).

Line A.6, contingency, was estimated at 10% of the applicant's construction cost in line A.5.

Line A.8 includes both fixed and moveable equipment costs, estimated by AmSurg development staff.

Line B.1 is the fair market value of the facility being leased. It was calculated in the two alternative ways required by HSDA rules. The lease outlay was the larger of these two alternative calculations and was used in Line B.1. The calculations were:

Lease Outlay Method: The lease option states the terms of the future lease. Its first term will be 15 years. The leasable area will be 17,173 rentable SF. The base lease rate will be $25.00 PSF in Year One, escalating 1% annually for the next 14 years. The total of first term lease payments will be $6,910,800.

Building Value Method: The developer provided complete capital cost data for acquisition and development of the site and the shell building. The total cost incurred by the developer to deliver a leasable shell building was estimated at $11,414,000. The developer has allocated to the ASTC floor a total capital cost of $4,037,000--which under CON rules would be the fair market value of the shell floor that the CON applicant will lease.

Line C.1, interim financing, was estimated as follows: (Part A + Part E costs) X 1/2 (average balance) X 5% interest X 1 year = $167,827.

PROJECT COSTS CHART—THE ENDOSCOPY CENTER OF KNOXVILLE

A.	Construction and equipment acquired by purchase:		
1.	Architectural and Engineering Fees		$ 283,007
2.	Legal, Administrative, Consultant Fees (Excl CON Filing Fee)		50,000
3.	Acquisition of Site		0
4.	Preparation of Site		0
5.	Construction Cost	16,732 SF @ $257 PSF	4,300,124
6.	Contingency Fund	10% of A.5	430,012
7.	Fixed Equipment (Not included in Construction Contract)		0
8.	Moveable Equipment (List all equipment over $50,000)		1,618,987
9.	Other (Specify)	misc. fees in A.5	0
B.	Acquisition by gift, donation, or lease:		
1.	Facility (inclusive of building and land)		6,910,800
2.	Building only		0
3.	Land only		0
4.	Equipment (Specify)		0
5.	Other (Specify)		0
C.	Financing Costs and Fees:		
1.	Interim Financing		167,827
2.	Underwriting Costs		
3.	Reserve for One Year's Debt Service		0
4.	Other (Specify)		0
D.	Estimated Project Cost (A+B+C)		13,760,757
E.	CON Filing Fee		30,962
F.	Total Estimated Project Cost (D+E)		TOTAL $ 13,791,719

Actual Capital Cost 6,880,919
Section B FMV 6,910,800

Interim Interest: (A + E) X 1/2 avg balance X 5% x 1 yr
($6,682,130 + $30,962 fee before this calculation) X .5 X .05 X 1 = $167,827

C(II).2. IDENTIFY THE FUNDING SOURCES FOR THIS PROJECT.

a. PLEASE CHECK THE APPLICABLE ITEM(S) BELOW AND BRIEFLY SUMMARIZE HOW THE PROJECT WILL BE FINANCED. (DOCUMENTATION FOR THE TYPE OF FUNDING MUST BE INSERTED AT THE END OF THE APPLICATION, IN THE CORRECT ALPHANUMERIC ORDER AND IDENTIFIED AS ATTACHMENT C, ECONOMIC FEASIBILITY--2).

___x__A. Commercial Loan--Letter from lending institution or guarantor stating favorable initial contact, proposed loan amount, expected interest rates, anticipated term of the loan, and any restrictions or conditions;

_____B. Tax-Exempt Bonds--copy of preliminary resolution or a letter from the issuing authority, stating favorable contact and a conditional agreement from an underwriter or investment banker to proceed with the issuance;

_____C. General Obligation Bonds--Copy of resolution from issuing authority or minutes from the appropriate meeting;

_____D. Grants--Notification of Intent form for grant application or notice of grant award;

_____E. Cash Reserves--Appropriate documentation from Chief Financial Officer; or

_____F. Other--Identify and document funding from all sources.

The project will be funded AmSurg Corp, which will loan to the applicant LLC the full actual capital expenses of the project--currently estimated at slightly less than $6,883,000. The availability of this financing is documented in Attachment C, Economic Feasibility--2, with a letter from the Chief Financial Officer of AmSurg. An amortization schedule that states the amount and terms of the loan is attached to that letter.

C(II).3. DISCUSS AND DOCUMENT THE REASONABLENESS OF THE PROPOSED PROJECT COSTS. IF APPLICABLE, COMPARE THE COST PER SQUARE FOOT OF CONSTRUCTION TO SIMILAR PROJECTS RECENTLY APPROVED BY THE HSDA.

The HSDA has calculated 2012-2014 ASTC construction cost averages for approved projects. However, there were too few samples to calculate renovation or new construction costs separately.

Ambulatory Surgery Center Construction Cost PSF Years: 2012-2014			
	Renovated Construction	New Construction	Total Construction
1st Quartile	$0/sq ft	$0/sq ft	$113.55/sq ft
Median	$0/sq ft	$0/sq ft	$150.00/sq ft
3rd Quartile	$0/sq ft	$0/sq ft	$174.88/sq ft

Source: HSDA Registry; CON approved applications for years 2012 through 2014

However, surgery center construction projects approved by the HSDA in 2011-2013 had the following construction costs per SF:

Ambulatory Surgery Center Construction Cost PSF Years: 2011-2013			
	Renovated Construction	New Construction	Total Construction
1st Quartile	$95.04/sq ft	$174.88/sq ft	$113.55/sq ft
Median	$113.55/sq ft	$223.62/sq ft	$162.00/sq ft
3rd Quartile	$150.00/sq ft	$269.76/sq ft	$223.62/sq ft

Source: HSDA Registry; CON approved applications for years 2011 through 2013

The applicant's build-out (renovation) cost of $257 PSF is above the HSDA's last calculated average third quartile cost for ASTC's. But this is reasonable due to the steady annual increase in construction costs since 2011, and the costs in the Knoxville market for such projects. The construction will be paid for in 2016, which is four years beyond the midpoint of the HSDA 2011-13 range.

Table Two-B (Repeated): Construction Costs of This Project			
	Applicant's Renovation	**Applicant's New Construction**	**Applicant's Total Construction**
Square Feet	16,732 SF	0	16,732 SF
Construction Cost	$4,300,124	0	$4,300,124
Constr. Cost PSF	$257 PSF	0	$257 PSF

C(II).4. COMPLETE HISTORICAL AND PROJECTED DATA CHARTS ON THE FOLLOWING TWO PAGES--DO NOT MODIFY THE CHARTS PROVIDED OR SUBMIT CHART SUBSTITUTIONS. HISTORICAL DATA CHART REPRESENTS REVENUE AND EXPENSE INFORMATION FOR THE LAST THREE (3) YEARS FOR WHICH COMPLETE DATA IS AVAILABLE FOR THE INSTITUTION. PROJECTED DATA CHART REQUESTS INFORMATION FOR THE TWO YEARS FOLLOWING COMPLETION OF THIS PROPOSAL. PROJECTED DATA CHART SHOULD INCLUDE REVENUE AND EXPENSE PROJECTIONS FOR THE PROPOSAL ONLY (I.E., IF THE APPLICATION IS FOR ADDITIONAL BEDS, INCLUDE ANTICIPATED REVENUE FROM THE PROPOSED BEDS ONLY, NOT FROM ALL BEDS IN THE FACILITY).

See the following pages for these charts, with notes where applicable. Please note that these charts and this application use calendar year data rather than the fiscal year (FYE June 30) data in the ASTC Joint Annual Reports.

HISTORICAL DATA CHART – THE ENDOSCOPY CENTER (KNOXVILLE)

Give information for the last three (3) years for which complete data are available for the facility or agency. The fiscal year begins in January.

		Year 2012	Year 2013	Year 2014
	Cases	11462	11251	9652
A.	Utilization Data			
B.	Revenue from Services to Patients			
1.	Inpatient Services	$		
2.	Outpatient Services	18,736,599	20,400,296	17,454,957
3.	Emergency Services			
4.	Other Operating Revenue			
	(Specify) See notes page			
	Gross Operating Revenue	$ 18,736,599	$ 20,400,296	$ 17,454,957
C.	Deductions for Operating Revenue			
1.	Contractual Adjustments	$ 12,437,647	14,100,654	12,064,650
2.	Provision for Charity Care	77,155	127,989	94,302
3.	Provisions for Bad Debt	193,001	64,813	122,883
	Total Deductions	$ 12,707,803	$ 14,293,456	$ 12,281,835
NET OPERATING REVENUE		$ 6,028,796	$ 6,106,840	$ 5,173,122
D.	Operating Expenses			
1.	Salaries and Wages	$ 2,755,690	2,878,240	2,407,309
2.	Physicians Salaries and Wages			
3.	Supplies	534,447	581,418	480,012
4.	Taxes	166,741	186,119	174,364
5.	Depreciation	296,698	238,173	231,163
6.	Rent	154,924	155,824	152,789
7.	Interest, other than Capital	213	(120)	(449)
8.	Management Fees			
	a. Fees to Affiliates	50,000	50,000	50,000
	b. Fees to Non-Affiliates			
9.	Other Expenses (Specify) See notes page	926,372	887,090	774,611
	Total Operating Expenses	$ 4,885,085	4,976,744	4,269,799
E.	Other Revenue (Expenses) -- Net (Specify)	$	$	$
NET OPERATING INCOME (LOSS)		$ 1,143,711	$ 1,130,096	$ 903,323
F.	Capital Expenditures			
1.	Retirement of Principal	$ 175,184	$ 194,119	$ 149,556
2.	Interest	13,941	8,203	2,316
	Total Capital Expenditures	$ 189,125	$ 202,322	$ 151,872
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES		$ 954,586	$ 927,774	$ 751,451

THE ENDOSCOPY CENTER (KNOXVILLE)
D9--OTHER EXPENSES

	HISTORIC DATA CHART			PROJECTED DATA CHART	
	CY 2012	CY 2013	CY 2014	CY 2017	CY 2018
7301-0000 Linen service	45,805	45,564	53,187	70,820	71,882
7303-0000 Cleaning service	14,620	14,084	11,601	68,692	69,722
7305-0000 Medical waste	32,343	6,249	10,186	13,563	13,766
7306-0000 Medical specialist fee	18,000	18,000	18,000	18,000	18,270
7307-0000 Transcription service	5,969	2,957	3,176	4,229	4,292
7311-0000 Accounting fees related party	4,603	4,603	4,603	4,603	4,672
7312-0000 Outside accounting services	27,820	28,080	48,027	31,200	31,668
7313-0000 Legal fees	-	206	-	-	-
7321-0000 Collection fees	24,908	22,396	25,657	34,163	34,675
7323-0000 Contract services	125,202	99,488	75,449	100,463	101,970
7327-0000 Uniform allowance	5,155	4,215	7,430	9,893	10,041
7329-0000 Patient transportation	-	-	-	-	-
7331-0000 GP travel	6,581	2,414	1,809	2,408	2,444
7333-0000 LP travel	11,608	10,593	14,246	18,969	19,254
7337-0000 Business meals and entertainment	9,266	11,413	3,190	4,247	4,311
7339-0000 Office supplies	98,750	94,940	69,968	93,166	94,563
7341-0000 Postage	23,377	20,908	20,190	26,884	27,287
7343-0000 Express delivery	758	951	1,045	1,392	1,413
7347-0000 Telephone	77,190	68,875	57,898	57,898	58,766
7349-0000 Dues and subscriptions	19,805	14,829	11,570	11,570	11,744
7351-0000 Meetings and conferences	1,923	7,234	11,211	11,211	11,379
7353-0000 Maintenance scopes	48,099	56,697	52,757	70,248	71,302
7355-0000 Maintenance other	68,908	62,797	45,434	62,797	63,739
7356-0000 Software maintenance contracts	69,520	114,468	95,945	107,925	109,544
7357-0000 Advertising	44,578	43,720	26,024	26,024	26,414
7361-0000 Donations and contributions	-	499	-	-	-
7363-0000 Employee recruiting cost	13,491	11,205	41	11,205	11,373
7369-0000 Other operating expense	29,684	18,884	12,858	17,120	17,377
7371-0000 Accreditation fee	11,934	-		11,934	12,113
7415-0000 CAM	-	12,256	12,065	103,038	104,584
7421-0000 Insurance malpractice	23,837	22,722	18,099	24,100	24,462
7422-0000 Insurance other	11,033	13,702	14,170	18,000	18,270
7431-0000 Utilities	57,824	57,443	53,155	120,211	122,014
8109-0000 Miscellaneous other income	(9,341)	(5,304)	(4,378)	(5,829)	(5,916)
8109-0000 Miscellaneous	2,999				
TOTAL	$926,248	$887,091	$774,611	$1,150,144	$1,167,396

SUPPLEMENTAL #1

PROJECTED DATA CHART– THE ENDOSCOPY CENTER (KNOXVILLE) August 25, 2015

(REVISED ON SUPPLEMENTAL CYCLE) 1:12 pm

Give information for the two (2) years following the completion of this proposal.

The fiscal year begins in January.

			CY 2017	CY 2018
A.	Utilization Data	Cases	12,852	12,981
B.	Revenue from Services to Patients			
	1. Inpatient Services		$	$
	2. Outpatient Services		23,474,349	23,946,184
	3. Emergency Services			
	4. Other Operating Revenue (Specify)	See notes page		
		Gross Operating Revenue	$ 23,474,349	$ 23,946,184
C.	Deductions for Operating Revenue			
	1. Contractual Adjustments		$ 15,026,121	$ 15,398,236
	2. Provision for Charity Care		1,344,498	1,371,522
	3. Provisions for Bad Debt		164,072	167,370
		Total Deductions	$ 16,534,691	$ 16,937,128
NET OPERATING REVENUE			$ 6,939,659	$ 7,009,056
D.	Operating Expenses			
	1. Salaries and Wages		$ 2,815,444	$ 2,871,753
	2. Physicians Salaries and Wages			0
	3. Supplies		648,702	661,676
	4. Taxes		220,741	225,156
	5. Depreciation		631,955	631,955
	6. Rent		470,027	479,428
	7. Interest, other than Capital		(449)	(458)
	8. Management Fees			0
	a. Fees to Affiliates		50,000	51,000
	b. Fees to Non-Affiliates			0
	9. Other Expenses (Specify)	See notes page	1,150,144	1,173,147
	Dues, Utilities, Insurance, and Prop Taxes.			
		Total Operating Expenses	$ 5,986,564	$ 6,093,656
E.	Other Revenue (Expenses) -- Net (Specify)		$	$
NET OPERATING INCOME (LOSS)			$ 953,095	$ 915,399
F.	Capital Expenditures			
	1. Retirement of Principal		$ 531,170	$ 557,729
	2. Interest		334,050	307,491
		Total Capital Expenditures	$ 865,220	$ 865,220
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES			$ 87,875	$ 50,179

C(II).5. PLEASE IDENTIFY THE PROJECT'S AVERAGE GROSS CHARGE, AVERAGE DEDUCTION FROM OPERATING REVENUE, AND AVERAGE NET CHARGE.

Table Nine: The Endoscopy Center (Knoxville) Average Charges, Deductions, and Net Charges		
	CY2017	**CY2018**
Cases	12,852	12,981
Average Gross Charge Per Case	$1,827	$1,845
Average Deduction Per Case	$1,287	$1,305
Average Net Operating Revenue Per Case	$540	$540
Average Net Operating Income Per Case Before Capital Expenditures	$74	$71

C(II).6.A. PLEASE PROVIDE THE CURRENT AND PROPOSED CHARGE SCHEDULES FOR THE PROPOSAL. DISCUSS ANY ADJUSTMENT TO CURRENT CHARGES THAT WILL RESULT FROM THE IMPLEMENTATION OF THE PROPOSAL. ADDITIONALLY, DESCRIBE THE ANTICIPATED REVENUE FROM THE PROPOSED PROJECT AND THE IMPACT ON EXISTING PATIENT CHARGES.

The applicant will not have its gross charge structure modified by this project. Projected charges in 2017 reflect a 1% increase from current charges; 2018 reflects another 1% increase over 2017.

C(II).6.B. COMPARE THE PROPOSED CHARGES TO THOSE OF SIMILAR FACILITIES IN THE SERVICE AREA/ADJOINING SERVICE AREAS, OR TO PROPOSED CHARGES OF PROJECTS RECENTLY APPROVED BY THE HSDA. IF APPLICABLE, COMPARE THE PROJECTED CHARGES OF THE PROJECT TO THE CURRENT MEDICARE ALLOWABLE FEE SCHEDULE BY COMMON PROCEDURE TERMINOLOGY (CPT) CODE(S).

Table Ten below compares the applicant's FYE 2014 and CY 2017 charges to the FYE 2014 charges of Nashville, Knoxville, and Maryville endoscopy centers.

Table Ten: Applicant's Charges in CY2017 Compared to FYE 2014 Charges at Dedicated Endoscopy Centers in Knoxville and Nashville

Facility	Cases (Patients)	Gross Charges	Gross Charges Per Case	Net Revenue	Net Revenue Per case
Digest. Disease Endo. Center (Nashville)	6,162	$9,148,179	$1,485	$5,242,063	$851
Nashville Endo. Center (Nashville)	2,870	$11,209,263	$3,906	$2,128,551	$742
The Applicant FYE 2014	**8,402**	**$17,668,336**	**$2,103**	**$5,367,724**	**$639**
The Applicant CY 2017	**12,852**	**$23,474,349**	**$1,827**	**$6,939,659**	**$540**
The Endoscopy Center West (Knox)	4,193	$8,937,499	$2,132	$2,501,911	$597
Associated Endoscopy (Nashville)	5,031	$8,220,082	$1,634	$2,902,350	$577
The Endoscopy Center North (Knoxville)	5,353	$11,650,650	$2,176	$3,018,963	$564
NV GI Endo. Center (Nashville)	2,594	$2,748,480	$1,060	$1,210,816	$467
Mid-State Endo. Center (Nashville)	2,436	$2,697,619	$1,107	$1,108,610	$455
Southern Endo. Center (Nashville)	2,711	$2,707,995	$999	$1,153,111	$425
Tennessee Endoscopy Center (Maryville)	7,081	$9,505,355	$1,342	$2,553,941	$361

Source: 2014 Joint Annual Reports of ASTC's and Projected Data Chart, this project.

The following page contains Table Eleven, showing the applicant's most frequent procedures performed, with their current Medicare reimbursement, and their projected Year One and Two average gross charges.

Table Eleven: Most Frequent Surgical Procedures and Average Gross Charges The Endoscopy Center (Knoxville)					
			Average Gross Charge		
CPT	Descriptor	Current Medicare Allowable	Current Average	Year 1 CY2017	Year 2 CY2018
43239	Upper gi endoscopy, biopsy	$347.81	$1,657	$1,674	$1,691
45380	Colonoscopy and biopsy	$368.45	$1,657	$1,674	$1,691
45385	Lesion removal colonoscopy	$368.45	$1,715	$1,732	$1,749
G0105	Colorectal scrn; hi risk individual	$305.56	$1,657	$1,674	$1,691
G0121	Colon ca scrn; not high risk	$305.56	$1,657	$1,674	$1,691
45378	Diagnostic colonoscopy	$368.45	$1,657	$1,674	$1,691
43248	Upper gi endoscopy/guide wire	$347.81	$1,657	$1,674	$1,691
43235	Upper gi endoscopy, diagnosis	$347.81	$1,657	$1,674	$1,691
43450	Dilate esophagus	$347.81	$1,246	$1,258	$1,271
45381	Colonoscopy, submuccous inj	$368.45	$1,657	$1,674	$1,691
45330	Flexible Sigmoidoscopy	$85.22	$652	$659	$661
46221	Hemmorrhoidectomy	$152.19	$1,077	$1,088	$1,099
45384	Lesion remove colonoscopy	$368.45	$1,715	$1,732	$1,749
43259	Endoscopic ultrasound exam	$496.73	$1,847	$1,865	$1,884
45331	Sigmoidoscopy and biopsy	$230.29	$1,246	$1,258	$1,271

Source: AmSurg

C(II).7. DISCUSS HOW PROJECTED UTILIZATION RATES WILL BE SUFFICIENT TO MAINTAIN COST-EFFECTIVENESS.

This is an existing endoscopy center that had a positive operating margin in 2014 and is operating currently with a positive margin. With a 2017 caseload larger than in 2014 and 2015, the facility is reasonably projected to maintain its cost-effectiveness while improving patient accessibility and improving facility efficiency.

C(II).8. DISCUSS HOW FINANCIAL VIABILITY WILL BE ENSURED WITHIN TWO YEARS; AND DEMONSTRATE THE AVAILABILITY OF SUFFICIENT CASH FLOW UNTIL FINANCIAL VIABILITY IS MAINTAINED.

This existing endoscopy center is financially viable and has a positive cash flow. Its Projected Data Chart for 2017-2018 indicates that positive cash flow will continue at the new location.

C(II).9. DISCUSS THE PROJECT'S PARTICIPATION IN STATE AND FEDERAL REVENUE PROGRAMS, INCLUDING A DESCRIPTION OF THE EXTENT TO WHICH MEDICARE, TENNCARE/MEDICAID, AND MEDICALLY INDIGENT PATIENTS WILL BE SERVED BY THE PROJECT. IN ADDITION, REPORT THE ESTIMATED DOLLAR AMOUNT OF REVENUE AND PERCENTAGE OF TOTAL PROJECT REVENUE ANTICIPATED FROM EACH OF TENNCARE, MEDICARE, OR OTHER STATE AND FEDERAL SOURCES FOR THE PROPOSAL'S FIRST YEAR OF OPERATION.

Table Twelve-A below shows The Endoscopy Center's current overall payor mix. The Medicare and TennCare/Medicaid payor mix for Year One at the new location are shown in Table Twelve-B. The applicant projects maintaining approximately the same Medicare and TennCare/Medicaid payor mix that is currently being experienced.

Table Twelve-A: The Endoscopy Center (Knoxville)
2014-15 Payor Mix

Payor	Percentage
Medicare	60.0%
TennCare/Medicaid	1.0%
Blue Cross	17.5%
Other	21.5%
Total	100.0%

Table Twelve-B: The Endoscopy Center (Knoxville)
Medicare and TennCare/Medicaid Revenues, Year One

	Medicare	TennCare/Medicaid
Gross Revenue	$14,084,609	$2,437,434
Percent of Gross Revenue	60%	1%

C(II).10. PROVIDE COPIES OF THE BALANCE SHEET AND INCOME STATEMENT FROM THE MOST RECENT REPORTING PERIOD OF THE INSTITUTION, AND THE MOST RECENT AUDITED FINANCIAL STATEMENTS WITH ACCOMPANYING NOTES, IF APPLICABLE. FOR NEW PROJECTS, PROVIDE FINANCIAL INFORMATION FOR THE CORPORATION, PARTNERSHIP, OR PRINCIPAL PARTIES INVOLVED WITH THE PROJECT. COPIES MUST BE INSERTED AT THE END OF THE APPLICATION, IN THE CORRECT ALPHANUMERIC ORDER AND LABELED AS ATTACHMENT C, ECONOMIC FEASIBILITY--10.

These are provided as Attachment C, Economic Feasibility--10.

C(II)11. DESCRIBE ALL ALTERNATIVES TO THIS PROJECT WHICH WERE CONSIDERED AND DISCUSS THE ADVANTAGES AND DISADVANTAGES OF EACH ALTERNATIVE, INCLUDING BUT NOT LIMITED TO:

A. A DISCUSSSION REGARDING THE AVAILABILITY OF LESS COSTLY, MORE EFFECTIVE, AND/OR MORE EFFICIENT ALTERNATIVE METHODS OF PROVIDING THE BENEFITS INTENDED BY THE PROPOSAL. IF DEVELOPMENT OF SUCH ALTERNATIVES IS NOT PRACTICABLE, THE APPLICANT SHOULD JUSTIFY WHY NOT, INCLUDING REASONS AS TO WHY THEY WERE REJECTED.

B. THE APPLICANT SHOULD DOCUMENT THAT CONSIDERATION HAS BEEN GIVEN TO ALTERNATIVES TO NEW CONSTRUCTION, E.G., MODERNIZATION OR SHARING ARRANGEMENTS. IT SHOULD BE DOCUMENTED THAT SUPERIOR ALTERNATIVES HAVE BEEN IMPLEMENTED TO THE MAXIMUM EXTENT PRACTICABLE.

The project site was chosen for its proximity to the current ASTC location, ease of interstate access, high visibility, and its location within a growing health care community of providers in the Dowell Springs area of Knox County.

The applicant cannot expand at its present location because no space is available for lease. At the proposed location, a third party will provide a newly constructed shell building; but the applicant's construction will all be build-out.

C(III).1. LIST ALL EXISTING HEALTH CARE PROVIDERS (I.E., HOSPITALS, NURSING HOMES, HOME CARE ORGANIZATIONS, ETC.) MANAGED CARE ORGANIZATIONS, ALLIANCES, AND/OR NETWORKS WITH WHICH THE APPLICANT CURRENTLY HAS OR PLANS TO HAVE CONTRACTUAL AND/OR WORKING RELATIONSHIPS, E.G., TRANSFER AGREEMENTS, CONTRACTUAL AGREEMENTS FOR HEALTH SERVICES.

The applicant has transfer agreements in place with Tennova Health System, whose replacement facility is being developed directly across Middlebrook Pike from the project site in Dowell Springs.

C(III).2. DESCRIBE THE POSITIVE AND/OR NEGATIVE EFFECTS OF THE PROPOSAL ON THE HEALTH CARE SYSTEM. PLEASE BE SURE TO DISCUSS ANY INSTANCES OF DUPLICATION OR COMPETITION ARISING FROM YOUR PROPOSAL, INCLUDING A DESCRIPTION OF THE EFFECT THE PROPOSAL WILL HAVE ON THE UTILIZATION RATES OF EXISTING PROVIDERS IN THE SERVICE AREA OF THE PROJECT.

Benefits

The project will be beneficial to the health care system. A severely undersized endoscopy center will be enlarged and redesigned to be highly efficient and patient-friendly.

Impact on Other Providers

1. AmSurg and GIA physicians own a network of three endoscopic ASTC's in Knox County: The Endoscopy Center on Weisgarber Road (the applicant in this project); the Endoscopy Center North; and the Endoscopy Center West. After the Weisgarber Road facility was forced to curtail its operating hours, many cases were moved to the North and West facilities. When the Weisgarber Road facility relocates to Dowell Springs, and resumes full-day operation, Dr. Matt Moore, who has been performing approximately 600 cases annually in the other two endoscopy centers, will transfer 600 cases to the main facility. This removal of cases from those facilities will still leave them with very high

utilization, as shown in Table Thirteen below--107% of the State Health Plan standard of 2,500 ambulatory surgery cases per procedure room.

2. Dr. Jeff Gilbert will transfer to this project approximately 2,200 endoscopy cases. He rerports that he currently performs those in nearby Oak Ridge at Covenant Health System's Methodist Medical Center and at the "Tennessee Endoscopy Center". The latter filed a JAR as a licensed ASTC for FYE2013. But it has been acquired by Covenant Health System and may be functioning now as a hospital-based outpatient department. The small impact of the project on Methodist Medical Center, based on the hospital's last reported (FY2013) total surgery cases, is shown in Table Thirteen below. Methodist Medical Center's FY 2014 surgical utilization is not known because its 2014 Joint Annual Report has not yet been released on the TDH website as of August 14, 2015. The volume in the table for Tennessee Endoscopy Center is from its CY2013 Joint Annual Report.

Table Thirteen: Impact of Project on Other Providers

Impacted Facility	Reported Surgical Rooms	Most Recent Reported Total Cases	Cases Moving To This Project	Percent Impact	Cases Per Room Before/After
Endoscopy Center North	2	6,237	--	--	--
Endoscopy Center West	2	4,929	--	--	--
Subtotal	*4*	*11,266*	*600*	*-5.3%*	*2,817 / 2,667*
Methodist Medical Cntr.	13	(CY 2013) 6,965	440	-6.3%	536 / 502
Tennessee Endo. Center	3	(FY2013) 4,838	1,760	-36.4%	1,613 / 1,026

Sources: Applicant and TDH Joint Annual Reports.

It should be noted that it is a significant financial benefit to patients and insurors for endoscopy cases to be performed in an ASTC environment, rather than in a hospital outpatient department (HOPD). Medicare and most insurers pay 30%-40% less for these cases if done in an ASTC rather than a hospital. The movement of Dr. Gilbert's cases from a hospital to an ASTC will generate a significant cost savings for the public. The great majority of endoscopic surgeries in Tennessee have already migrated into ASTC's, for that and other reasons.

C(III).3. PROVIDE THE CURRENT AND/OR ANTICIPATED STAFFING PATTERN FOR ALL EMPLOYEES PROVIDING PATIENT CARE FOR THE PROJECT. THIS CAN BE REPORTED USING FTE'S FOR THESE POSITIONS. IN ADDITION, PLEASE COMPARE THE CLINICAL STAFF SALARIES IN THE PROPOSAL TO PREVAILING WAGE PATTERNS IN THE SERVICE AREA AS PUBLISHED BY THE TENNESSEE DEPARTMENT OF LABOR & WORKFORCE DEVELOPMENT AND/OR OTHER DOCUMENTED SOURCES.

The Department of Labor and Workforce Development website indicates the following Upper Central Tennessee region's annual salary information for clinical employees of this project:

Table Fourteen: TDOL Surveyed Average Salaries for the Region				
Position	Entry Level	Mean	Median	Experienced
RN	$46,246	$57,282	$56,767	$62,800
Medical Assistant	$21,537	$28,410	$26,639	$31,847

Source: TDOLWD 2014 Survey, Knoxville Area

Table Fifteen on the following page provides current and proposed staffing patterns for the facility.

Table Fifteen: The Endoscopy Center (Knoxville) Current and Projected Staffilng				
Position Type (RN, etc.)	**Current FTE'S**	**Year One FTE's**	**Year Two FTE's**	**Annual Salary Range ($)**
Center Administrator (RN)	0.3	0.3	1.0	66,000 - 87,000
Charge RNs	1.4	1.4	4.4	56,000 - 72,000
Staff RNs	9.4	11.1	8.3	41,600 - 62,400
LPNs	2.2	2.5	2.6	
Endoscopy Techs	7.0	8.0	8.0	25,000 - 40,000
Medical Assistants	2.6	2.7	2.7	25,000 - 40,000
Receptionists	9.1	11.6	11.7	25,000 - 41,600
Schedulers	2.0	2.0	2.0	25,000 - 35,000
Billing	6.4	7.5	7.7	22,000 - 65,000
Medical Records	2.0	2.3	2.4	25,000 - 36,000
Total FTE's	**42.2**	**49.5**	**50.7**	

Source: AmSurg

C(III).4. DISCUSS THE AVAILABILITY OF AND ACCESSIBILITY TO HUMAN RESOURCES REQUIRED BY THE PROPOSAL, INCLUDING ADEQUATE PROFESSIONAL STAFF, AS PER THE DEPARTMENT OF HEALTH, THE DEPARTMENT OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES, AND/OR THE DIVISION OF MENTAL RETARDATION SERVICES LICENSING REQUIREMENTS.

The applicant has excellent access to pools of clinical personnel in the East Tennessee market. AmSurg recruits both Statewide and nationally for its nurses and other clinical employees.

C(III).5. VERIFY THAT THE APPLICANT HAS REVIEWED AND UNDERSTANDS THE LICENSING CERTIFICATION AS REQUIRED BY THE STATE OF TENNESSEE FOR MEDICAL/CLINICAL STAFF. THESE INCLUDE, WITHOUT LIMITATION, REGULATIONS CONCERNING PHYSICIAN SUPERVISION, CREDENTIALING, ADMISSIONS PRIVILEGES, QUALITY ASSURANCE POLICIES AND PROGRAMS, UTILIZATION REVIEW PPOLICIES AND PROGRAMS, RECORD KEEPING, AND STAFF EDUCATION.

The applicant so verifies.

C(III).6. DISCUSS YOUR HEALTH CARE INSTITUTION'S PARTICIPATION IN THE TRAINING OF STUDENTS IN THE AREAS OF MEDICINE, NURSING, SOCIAL WORK, ETC. (I.E., INTERNSHIPS, RESIDENCIES, ETC.).

This small facility does not participate in the training of students.

C(III).7(a). PLEASE VERIFY, AS APPLICABLE, THAT THE APPLICANT HAS REVIEWED AND UNDERSTANDS THE LICENSURE REQUIREMENTS OF THE DEPARTMENT OF HEALTH, THE DEPARTMENT OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES, THE DIVISION OF MENTAL RETARDATION SERVICES, AND/OR ANY APPLICABLE MEDICARE REQUIREMENTS.

The applicant so verifies.

C(III).7(b). PROVIDE THE NAME OF THE ENTITY FROM WHICH THE APPLICANT HAS RECEIVED OR WILL RECEIVE LICENSURE, CERTIFICATION, AND/OR ACCREDITATION

LICENSURE:	Board for Licensure of Healthcare Facilities Tennessee Department of Health
CERTIFICATION:	Medicare Certification from CMS TennCare Certification from TDH
ACCREDITATION:	Accreditation Association for Ambulatory Healthcare (AAAHC)

C(III).7(c). IF AN EXISTING INSTITUTION, PLEASE DESCRIBE THE CURRENT STANDING WITH ANY LICENSING, CERTIFYING, OR ACCREDITING AGENCY OR AGENCY.

The applicant is currently licensed in good standing by the Board for Licensing Health Care Facilities, is certified for participation in Medicare and TennCare, and is fully accredited by the Accreditation Association for Ambulatory Healthcare (AAAHC).

C(III).7(d). FOR EXISTING LICENSED PROVIDERS, DOCUMENT THAT ALL DEFICIENCIES (IF ANY) CITED IN THE LAST LICENSURE CERTIFICATION AND INSPECTION HAVE BEEN ADDRESSED THROUGH AN APPROVED PLAN OF CORRECTION. PLEASE INCLUDE A COPY OF THE MOST RECENT LICENSURE/CERTIFICATION INSPECTION WITH AN APPROVED PLAN OF CORRECTION.

They have been addressed. A copy of the most recent licensure inspection and plan of correction, and/or the most recent accreditation inspection, are provided in Attachment C, Orderly Development--7(C).

C(III)8. DOCUMENT AND EXPLAIN ANY FINAL ORDERS OR JUDGMENTS ENTERED IN ANY STATE OR COUNTRY BY A LICENSING AGENCY OR COURT AGAINST PROFESSIONAL LICENSES HELD BY THE APPLICANT OR ANY ENTITIES OR PERSONS WITH MORE THAN A 5% OWNERSHIP INTEREST IN THE APPLICANT. SUCH INFORMATION IS TO BE PROVIDED FOR LICENSES REGARDLESS OF WHETHER SUCH LICENSE IS CURRENTLY HELD.

None.

C(III)9. IDENTIFY AND EXPLAIN ANY FINAL CIVIL OR CRIMINAL JUDGMENTS FOR FRAUD OR THEFT AGAINST ANY PERSON OR ENTITY WITH MORE THAN A 5% OWNERSHIP INTEREST IN THE PROJECT.

None.

C(III)10. IF THE PROPOSAL IS APPROVED, PLEASE DISCUSS WHETHER THE APPLICANT WILL PROVIDE THE THSDA AND/OR THE REVIEWING AGENCY INFORMATION CONCERNING THE NUMBER OF PATIENTS TREATED, THE NUMBER AND TYPE OF PROCEDURES PERFORMED, AND OTHER DATA AS REQUIRED.

Yes. The applicant will provide the requested data consistent with Federal HIPAA requirements.

PROOF OF PUBLICATION

Attached.

DEVELOPMENT SCHEDULE

1. PLEASE COMPLETE THE PROJECT COMPLETION FORECAST CHART ON THE NEXT PAGE. IF THE PROJECT WILL BE COMPLETED IN MULTIPLE PHASES, PLEASE IDENTIFY THE ANTICIPATED COMPLETION DATE FOR EACH PHASE.

The Project Completion Forecast Chart is provided after this page.

2. IF THE RESPONSE TO THE PRECEDING QUESTION INDICATES THAT THE APPLICANT DOES NOT ANTICIPATE COMPLETING THE PROJECT WITHIN THE PERIOD OF VALIDITY AS DEFINED IN THE PRECEDING PARAGRAPH, PLEASE STATE BELOW ANY REQUEST FOR AN EXTENDED SCHEDULE AND DOCUMENT THE "GOOD CAUSE" FOR SUCH AN EXTENSION.

Not applicable. The applicant anticipates completing the project within the period of validity.

PROJECT COMPLETION FORECAST CHART

Enter the Agency projected Initial Decision Date, as published in Rule 68-11-1609(c):

November 18, 2015

Assuming the CON decision becomes the final Agency action on that date, indicate the number of days from the above agency decision date to each phase of the completion forecast.

PHASE	DAYS REQUIRED	Anticipated Date (MONTH /YEAR)
1. Architectural & engineering contract signed	12	12-15
2. Construction documents approved by TDH	102	2-16
3. Construction contract signed	116	2-16
4. Building permit secured	121	2-16
5. Site preparation completed	na	na
6. Building construction commenced	131	3-16
7. Construction 40% complete	221	6-16
8. Construction 80% complete	311	9-16
9. Construction 100% complete	401	11-16
10. * Issuance of license	415	12-16
11. *Initiation of service	417	1-17
12. Final architectural certification of payment	477	3-17
13. Final Project Report Form (HF0055)	537	5-17

*** For projects that do NOT involve construction or renovation: please complete items 10-11 only.**

Note: If litigation occurs, the completion forecast will be adjusted at the time of the final determination to reflect the actual issue date.

SUPPLEMENTAL #1
August 25, 2015
1:12 pm

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF DAVIDSON

JOHN WELLBORN, being first duly sworn, says that he is the lawful agent of the applicant named in this application, that this project will be completed in accordance with the application to the best of the agent's knowledge, that the agent has read the directions to this application, the Rules of the Health Services and Development Agency, and T.C.A. § 68-11-1601, *et seq.*, and that the responses to this application or any other questions deemed appropriate by the Health Services and Development Agency are true and complete to the best of the agent's knowledge.

John L Wellborn
SIGNATURE/TITLE
CONSULTANT

Sworn to and subscribed before me this 14th day of August (Month), 2015 (Year) a Notary

Public in and for the County/State of DAVIDSON

Jan M. Danforth
NOTARY PUBLIC

My commission expires July 2, (Month/Day), 2018 (Year).

JAN M. DANFORTH
STATE OF TENNESSEE NOTARY PUBLIC
DAVIDSON COUNTY
My Commission Expires July 2, 2018

INDEX OF ATTACHMENTS

A.4--Ownership
Legal Entity and Organization Chart

B.II.A.--Square Footage and Costs Per Square Footage Chart

SQUARE FOOTAGE AND COST PER SQUARE FOOTAGE CHART
THE ENDOSCOPY CENTER
KNOXVILLE

A. Unit / Department	Existing Location	Existing SF	Temporary Location	Proposed Final Location	Proposed Final Square Footage			Proposed Final Cost / SF		
					Renovated	New	Total	Renovated	New	Total
Public Reception/Wait				2nd	3,636		3,636	$210.00		$736,560.00
Business Office				2nd	1,162		1,162	$180.00		$209,160.00
Pre-Op				2nd	2,041		2,041	$290.00		$591,890.00
Post-Op				2nd	4,035		4,035	$290.00		$1,170,150.00
Support				2nd	2,731		2,731	$200.00		$546,200.00
Procedure Rms/Corridor				2nd	2,450		2,450	$300.00		$735,000.00
Out Building Support				outdoors	500		500	$550.00		$275,000.00
B. Unit/Dept. USF Sub-Total							16,555			$4,263,960.00
C. Mechanical / Electrical USF				2nd			177	$204.32		$36,164.00
D. Circulation / Structure USF							included above			
E. Total USF							16,732			$4,300,124.00

B.III.--Plot Plan

CERTIFICATE OF OWNERSHIP & GENERAL DEDICATION

Signed: Debra C. Smith, EVP

State of Tennessee County of Knox

On this 9th day of June 2015

Before me personally appeared Debra C. Smith

STATE OF TENNESSEE NOTARY PUBLIC KNOX COUNTY

CERTIFICATE OF OWNERSHIP & GENERAL DEDICATION

JERRY BODIE, DOWELL SPRINGS CO.

Signed: Jerry L. Bodie

State of Tennessee County of Knox

On this 9th day of June 2015

Before me personally appeared Jerry L. Bodie

My Commission expires 2/5/19

CERTIFICATE OF OWNERSHIP & GENERAL DEDICATION

EAST TENNESSEE HEALTHREALTY LLC

Signed: Mary Lou DuBois, President

State of Tennessee County of Anderson

On this 17th day of June 2015

Before me personally appeared Mary Lou DuBois

My Commission expires 6-27-15

CITY OF KNOXVILLE ENGINEERING DIVISION

The Knoxville Engineering Division hereby approves this plat on this the 17 day of June 2015

Engineering Director

CERTIFICATION OF CATEGORY AND ACCURACY OF SURVEY

Registered Land Surveyor NED D FERGUSON

Tenn. Reg. No. 1643

CERTIFICATION OF FINAL PLAT CONSTRUCTION COMPLETE

IN THE CITY OF KNOXVILLE AND SEWERED AREAS OF KNOX COUNTY

Date 6-10-15

ZONING

Zoning Shown on Official Map: PC-1 + O-1

Date 6/10/15

CERTIFICATE OF APPROVAL FOR RECORDING ADMINISTRATIVE PLAT

Date 6-11-15

THIS IS TO CERTIFY THAT ALL PROPERTY TAXES AND ASSESSMENTS DUE ON THIS PROPERTY HAVE BEEN PAID.

Knox County Trustee: Ed Shouse

Date 6-10-15

ADDRESSING DEPARTMENT CERTIFICATION

Paula Nicely-KUB 6-10-15

AT&T 6-10-15

6.11.15

GRAPHIC SCALE

(IN FEET)

1 inch = 60 ft.

1. THIS SURVEY IS SUBJECT TO ALL EASEMENTS AND RESTRICTIONS OF RECORD.

2. SIGNIFICANT OBSERVABLE EVIDENCE OF UTILITIES IS SHOWN. OTHER UTILITIES MAY EXIST AND NOT BE SHOWN. NO GUARANTEE IS EXPRESSED OR IMPLIED AS TO THE LOCATION OF ANY UTILITIES WHICH ARE NOT VISIBLE FROM THE SURFACE.

3. TAX PARCELS [illegible]

4. SUBJECT TO UTILITY & DRAINAGE EASEMENTS OF 5' INSIDE INTERIOR LOT LINES; 10' INSIDE EXTERIOR LOT LINES AND ROADS.

5. DEED [illegible]

6. IRON PINS SET AT ALL CORNERS NOT OTHERWISE IDENTIFIED.

7. CITY BLOCK NO. [illegible]

8. THE PURPOSE OF THIS PLAT IS TO CLOSE THE J.P.E. AND CONVEY TO THE ADJACENT OWNERS AS SHOWN, AND COMBINE LOTS 4R1 AND 4R2.

9. THE PROPERTY OWNERS ARE RESPONSIBLE FOR MAINTAINING ALL STORMWATER FACILITIES ON THIS PROPERTY AS PER THE MAINTENANCE AGREEMENT FOR STORMWATER FACILITIES RECORDED IN INSTRUMENT [illegible]

10. MAINTENANCE AGREEMENT BETWEEN THE CITY OF KNOXVILLE AND DOWELL SPRINGS COMPANY, A TENNESSEE GENERAL PARTNERSHIP REGARDING THE [illegible]

11. VARIANCES APPROVED BY THE CITY OF KNOXVILLE BOARD OF ZONING APPEALS, [illegible] AS FOLLOWS (LOT 4R6-1):

A. REDUCE THE PERIPHERAL BOUNDARY ON DICK LONAS ROAD FROM 35 FEET TO 25 FEET.
B. REDUCE THE PERIPHERAL BOUNDARY ON MEADOW GREEN WAY FROM 50 FEET TO 25 FEET.
C. REDUCE THE PERIPHERAL BOUNDARY ON DOWELL SPRINGS BLVD. FROM 50 FEET TO 25 FEET.

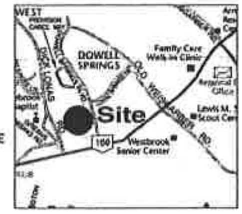
12. DECLARATION OF PROTECTIVE COVENANTS, CONDITIONS, RESTRICTIONS, AND OWNERS ASSOCIATION FOR DOWELL SPRINGS RECORDED IN INSTRUMENT [illegible]

13. SUBJECT TO SANITARY SEWER EASEMENTS OF 15 FEET (7.5 FEET EACH SIDE OF LINE) ALONG SANITARY SEWER AS INSTALLED.

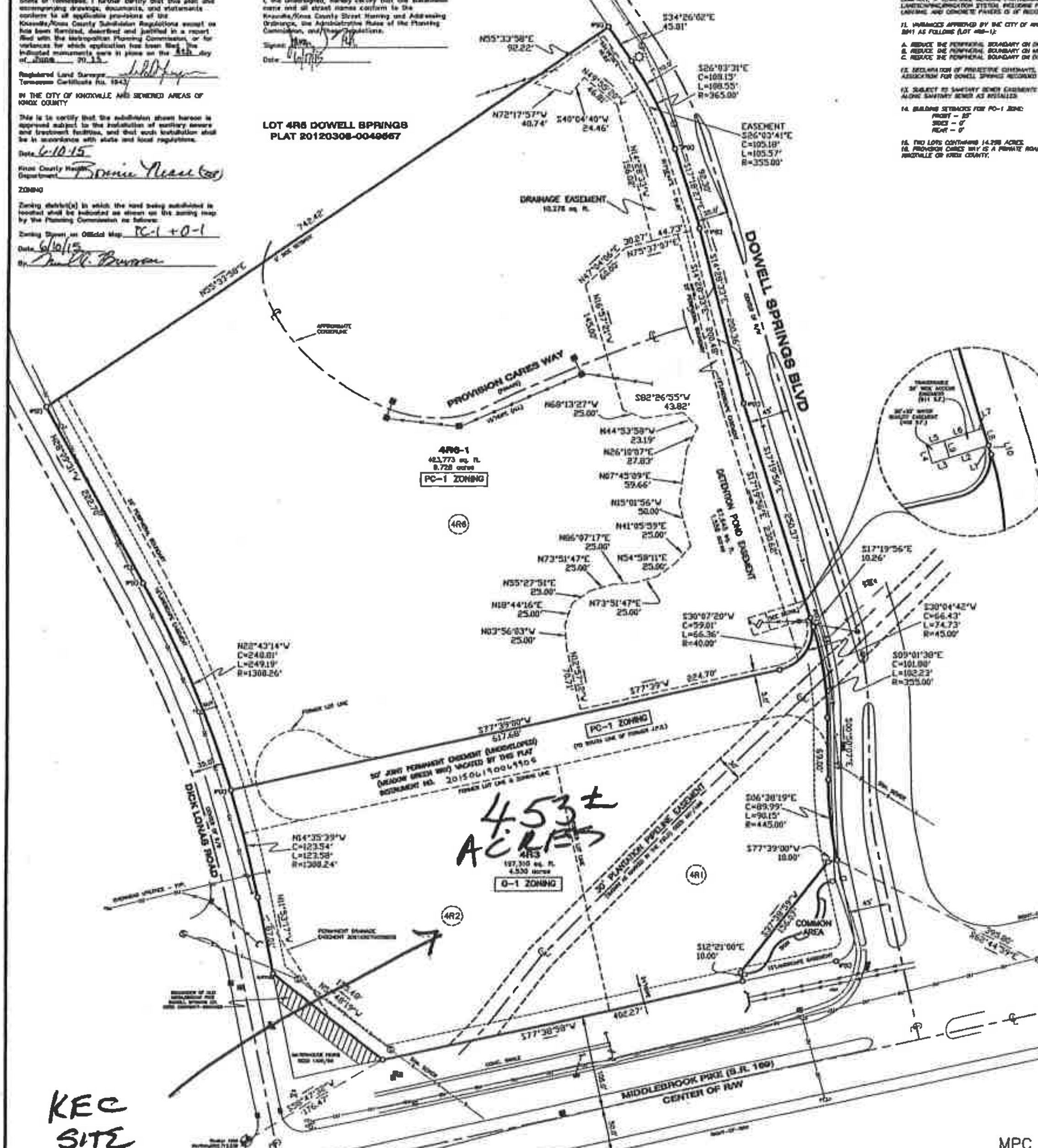
14. BUILDING SETBACKS FOR PC-1 ZONE:
FRONT – 25'
SIDES – 0'
REAR – 0'

15. TWO LOTS CONTAINING 14.298 ACRES.

16. PROVISION CARES WAY IS A PRIVATE ROAD AND IS NOT TO BE MAINTAINED BY THE CITY OF KNOXVILLE OR KNOX COUNTY.



KNOXVILLE UTILITIES BOARD DOES NOT RELEASE AND HEREBY RETAINS ALL EASEMENTS AND RIGHTS FOR EXISTING UTILITY FACILITIES, WHETHER OR NOT SHOWN ON THIS PLAT.



LINE TABLE		
LINE	LENGTH	BEARING
L1	5.00	S72°40'00"W
L2	40.53	S72°40'00"W
L3	20.00	S72°40'00"W
L4	20.00	N17°20'00"W
L5	20.00	N72°40'00"E
L6	35.53	N72°40'00"E
L7	10.00	N72°40'00"E
L8	20.00	S17°19'56"E
L9	20.00	S17°20'00"E
L10	10.26	N17°19'56"W

LEGEND
CURB INLET
WATER VALVE
SEWER MANHOLE
STORM MANHOLE
TELCO MANHOLE
UTILITY POLE
ELECTRIC MANHOLE
FIRE HYDRANT
CATCH BASIN

MPC FILE 5-E-15

Sherry Witt
Register of Deeds
Knox County

201506190069904

COUNTERSIGNED

JUN 19 2015

Call Before You Dig! 1-800-351-1111

OWNER LOT 4R1:
HOME FEDERAL BANK OF TN
KNOXVILLE, TN

OWNER LOT 4R2 & J.P.E.:
DOWELL SPRINGS Company
KNOXVILLE, TN

OWNER LOT 4R6:
EAST TENNESSEE HEALTHREALTY LLC
KNOXVILLE, TN

NED D. FERGUSON TENNESSEE NO. 1643

FINAL PLAT OF DOWELL SPRINGS RESUBDIVISION OF LOTS 4R1, 4R2, 4R6, AND J.P.E. MEADOWGREEN WAY
PREVIOUS PLAT LOTS 4R1 & 4R2 INST. 200305010089378
PREVIOUS PLAT LOT 4R6 INST. 20120308-0049567

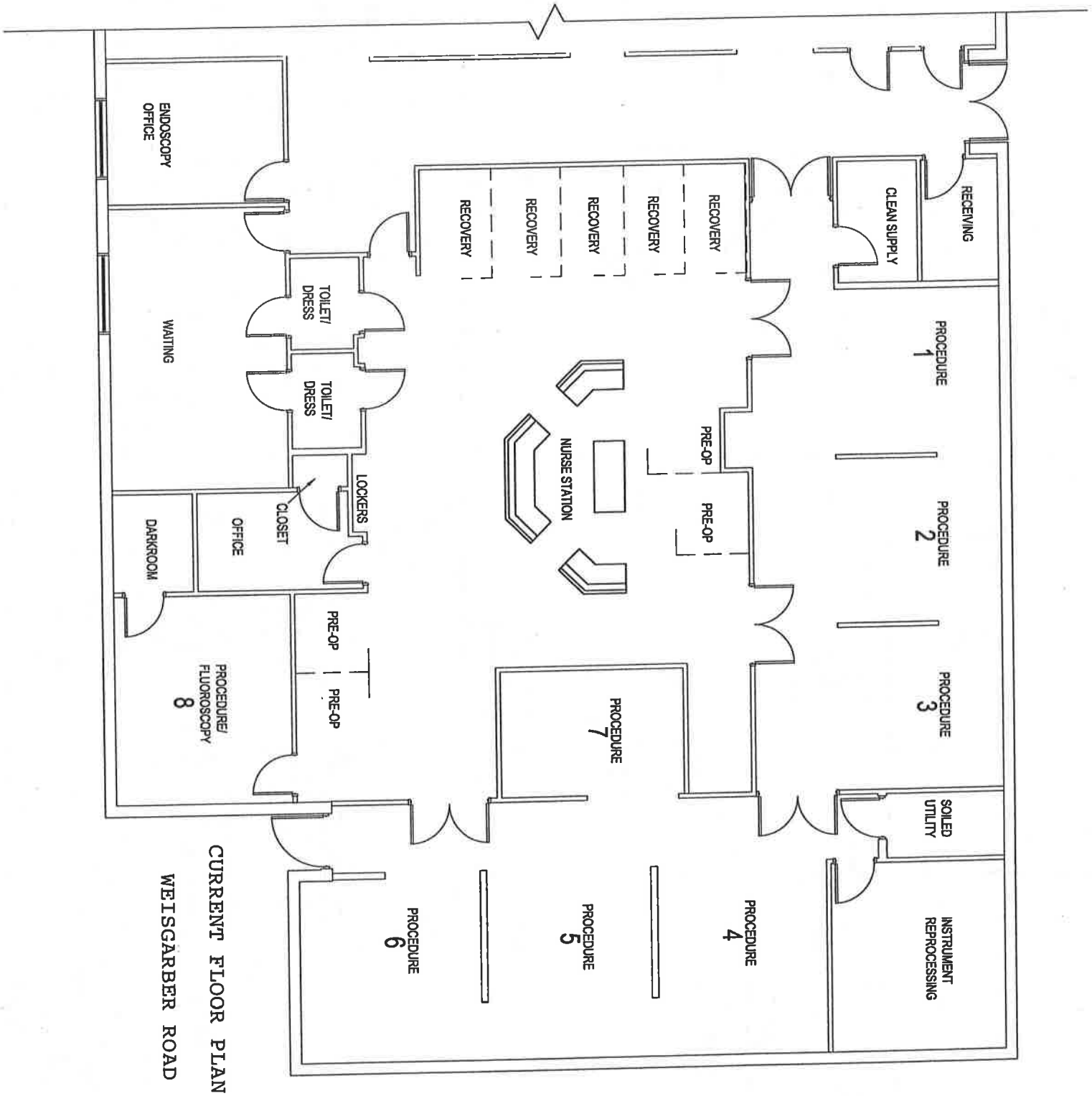
COUNTY: KNOX DISTRICT: 5 CITY: KNOXVILLE WARD: 45	DATE: 4/27/2015 SCALE: 1"=60' DRAWN BY: NDF

Ned D. Ferguson, R.L.S.
205 Lamar Avenue
Clinton, Tn. 37716
Phone: (865) 680-6168
Fax: (888) 232-8718 Toll Free

Professional Land Systems
www.PLSurvey.com

When you need to know, knowing is our business.

B.IV.--Floor Plan



CURRENT FLOOR PLAN

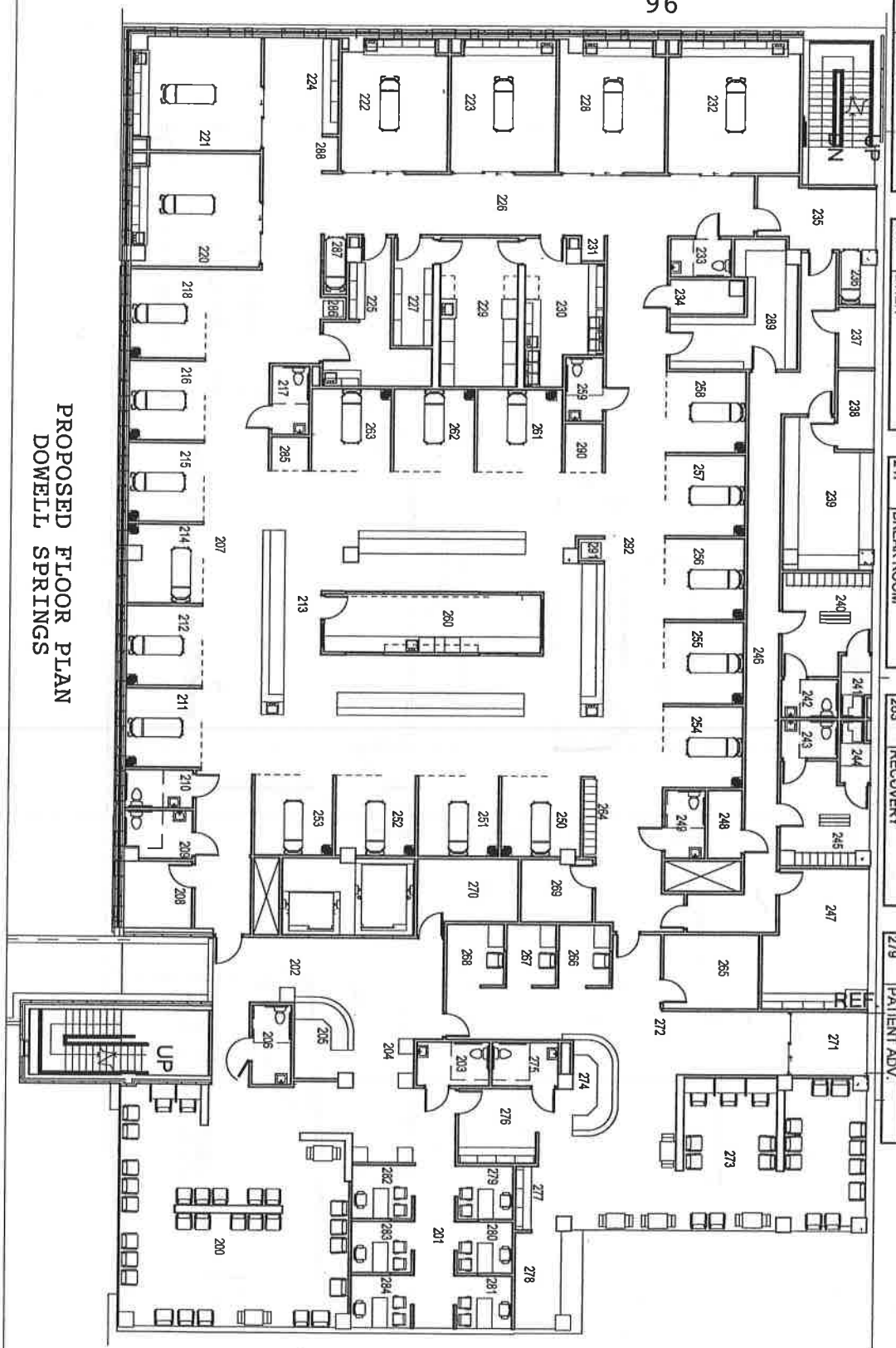
WEISGARBER ROAD

PROJECT # :	14075CON
DATE :	06-22-15
SHEET # :	CON -2
REFERENCE :	

THE ENDOSCOPY CENTER
801 WEISGARBER ROAD
KNOXVILLE, TN 37909

DIA
Design Innovation
ARCHITECTS + INTERIORS + PLANNING

402 S. Gay Street, Suite 201, Knoxville, TN 37902
ph 865.637.8540 or 865.291.2221 fx 865.544.3840
www.dia-arch.com



PROPOSED FLOOR PLAN
DOWELL SPRINGS

ROOM LISTING

NO.	ROOM NAME
200	WAITING 33 SEATS
201	CORRIDOR
202	CORRIDOR
203	PATIENT TOILET
204	SELF CHECK-IN
205	GREETER
206	PATIENT TOILET
207	CORRIDOR
208	UNIT DIRECTOR
209	PATIENT TOILET
210	PATIENT TOILET
211	PRE-OP
212	PRE-OP
213	NURSE STATION
214	PRE-OP
215	PRE-OP

ROOM LISTING

NO.	ROOM NAME
216	PRE-OP
217	PATIENT TOILET
218	PRE-OP
219	SOILED UTILITY
220	PROCEDURE
221	PROCEDURE
222	PROCEDURE
223	PROCEDURE
224	CORRIDOR
225	SOILED WORKROOM
226	CORRIDOR
227	SCOPES STORAGE
228	PROCEDURE
229	WASH
230	PRE-WASH
231	LINEN

ROOM LISTING

NO.	ROOM NAME
232	PROCEDURE/FLUOR
233	PATIENT TOILET
234	JANITOR
235	AIR LOCK
236	GURNEY
237	BIO HAZARD
238	REC'G
239	SUPPLY
240	LOCKER
241	SHOWER
242	STAFF TOILET
243	STAFF TOILET
244	SHOWER
245	LOCKER
246	CORRIDOR
247	BREAK ROOM

ROOM LISTING

NO.	ROOM NAME
248	CLOSET
249	PATIENT TOILET
250	RECOVERY
251	RECOVERY
252	RECOVERY
253	RECOVERY
254	RECOVERY
255	RECOVERY
256	RECOVERY
257	RECOVERY
258	RECOVERY
259	PATIENT TOILET
260	NURSE WORK ROOM
261	RECOVERY
262	RECOVERY
263	RECOVERY

ROOM LISTING

NO.	ROOM NAME
264	LOCKERS
265	CON/WK ROOM
266	SCHEDULE
267	SCHEDULE
268	SCHEDULE
269	ANESTHESIA OFFICE
270	ELECT/MECH
271	AIR LOCK
272	CORRIDOR
273	WAITING 28 SEATS
274	CHECK OUT
275	STAFF TOILET
276	WORK ROOM
277	BEV BAR
278	KIDS
279	PATIENT ADV.

ROOM LISTING

NO.	ROOM NAME
280	PATIENT ADV.
281	PATIENT ADV.
282	PATIENT ADV.
283	PATIENT ADV.
284	PATIENT ADV.
285	LINEN WHEEL CHAIR
286	CRASH
287	GURNEY
288	LINEN
289	SUPPLY
290	LINEN WHEEL CHAIR
291	CRASH
292	CORRIDOR

PROJECT #:	14075
DATE:	06/22/2015
SHEET #:	CON
REFERENCE:	

A NEW FACILITY FOR:
THE ENDOSCOPY CENTER
DOWELL SPRINGS

DIA
Design Innovation
ARCHITECTS + INTERIORS + PLANNING

402 S. Gay Street, Suite 201, Knoxville, TN 37902
ph 865.637.8540 or 865.291.2221 fx 865.544.3840
www.dia-arch.com

C, Need--1.A
Documentation of Project-Specific Criteria

C, Need--1.A.3.e.
Letters of Intent & Qualifications

GASTROINTESTINAL
ASSOCIATES, P.C.

BERGEIN F. OVERHOLT, MD, MACP, MACG, FASGE
BARRY V. MAVES, MD, FACG
SARKIS J. CHOBANIAN, MD, FACP, MACG
CHARLES M. O'CONNOR, MD, FACG
MEADE C. EDMUNDS, MD, FACG
JOHN M. HAYDEK, MD, FACP, FACG, AGAF, FASGE
MARIA B. NEWMAN, MD, DIPLOMAT ABIM
RAJ I. NARAYANI, MD, FACG, FASGE
STEVEN J. BINDRIM, MD, DIPLOMAT ABIM
SCOTT L. WILHOITE, MD
JOHNNY ALTAWIL, MD
J. MATTHEW MOORE, MD

JEFF DEW, CPA
CEO

August 11, 2015

Kimberly Walsh
Division Vice President – Operations
AmSurg Corporation
1A Burton Hills Boulevard
Nashville, Tennessee 37215

Dear Ms. Walsh:

We, the undersigned, are gastroenterologist who perform endoscopic surgeries in the Knoxville area.

This letter is to support the proposed relocation of The Endoscopy Center, where we have surgical privileges.

That facility's current utilization is very high relative to its restricted operating hours. There is insufficient room for us to perform the surgeries there that we would like to perform.

However, in 2017, when it has relocated with Certificate of Need Approval to the new building at Dowell Springs, with normal daily operating hours, we anticipate performing the following annual number of cases there. These are currently being done in other area facilities, as indicated.

Physician	Cases	Where Now Performed
Jeffrey Gilbert, M.D.	440	Methodist Medical Center, Oak Ridge
	1,760	The Endoscopy Center of Oak Ridge
J. Matthew Moore, M.D.	600	The Endoscopy Center North The Endoscopy Center West

MAIN OFFICE
801 WEISGARBER ROAD, #100
KNOXVILLE, TN 37909
P.O. BOX 59002
KNOXVILLE, TN 37950-9002
865.588.5121
FAX 865.588.2126
PLEASE VISIT US AT:
www.gihealthcare.com

NORTH OFFICE
629 DELOZIER WAY
P.O. BOX 59002
KNOXVILLE, TN 37950-9002
865.588.5121
FAX 865.588.2126

WEST OFFICE
11440 PARKSIDE DRIVE
P.O. BOX 59002
KNOXVILLE, TN 37950-9002
865.588.5121
FAX 865.588.2126

American Board of Internal Medicine®

Home | Search results for Name BERGEIN F OVERHOLT

Search results for Name BERGEIN F OVERHOLT

June 30, 2015

Overholt, Bergein F.

Gastroenterology: **Certified**
Internal Medicine: **Certified**

Participating in Maintenance of Certification: **No**

INITIAL CERTIFICATION
Internal Medicine: 1968
Gastroenterology: 1970

Search again

Name | ABIM ID | NPI#

First (if known): BERGEIN
Middle (if known): F
Last (required): OVERHOLT
DOB (if known) mm/dd/yy format
Match Exactly | Show All
Is Similar | Show 20
Go

Check a physician's ABIM Board Certification status by searching name, ABIM ID or NPI# by using the verification tool (at top right).

Important information regarding the physician verification tool:

- Most diplomates certified prior to 1990 are not required to participate in MOC but are strongly encouraged to do so.
- All ABIM certifications issued in 1990 (1987 for critical care medicine and 1988 for geriatric medicine) and thereafter must be maintained through ABIM's MOC program.
- ABIM's website serves as primary source verification.
- Diplomates are publicly reported as participating in MOC for all certifications as long as they are participating in MOC for one certification area.
- Certification status is updated to this system within 5 days of notification to the physicians. Data elements, such as name changes, are updated in ABIM's records within 24 hours of being processed by ABIM.
- If you do not find your physician or they are listed as not certified, they may be certified by another board of the American Board of Medical Specialties. Please check www.certificationmatters.org. Additionally, information on Allergy and Immunology, Clinical Laboratory Immunology and Diagnostic Laboratory Immunology diplomates can be now found at www.certificationmatters.org.

For more information about ABIM certification and MOC, go to:

MOC Requirements
Annual Reverification Date – April 1st
Reporting Certification Status
Board Eligibility

American Board of Internal Medicine®

Home | Search results for Name BARRY V MAVES

Search results for Name BARRY V MAVES

June 30, 2015

Maves, Barry V.

Gastroenterology: **Certified**
Internal Medicine: **Certified**

Participating in Maintenance of Certification: **Yes**

INITIAL CERTIFICATION
Internal Medicine: 1983
Gastroenterology: 1985

Search again

Name | ABIM ID | NPI#

First (if known): BARRY
Middle (if known): V
Last (required): MAVES
DOB (if known): mm/dd/yy format
Match Exactly | Show All
Is Similar | Show 20
Go

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MOC Requirements
Annual Reverification Date – April 1st
Reporting Certification Status
Board Eligibility

American Board of Internal Medicine®

Home | Search results for Name SARKIS J CHOBANIAN

Search results for Name SARKIS J CHOBANIAN

June 30, 2015

Chobanian, Sarkis J.

Gastroenterology: **Certified**
Internal Medicine: **Certified**

Participating in Maintenance of Certification: **No**

INITIAL CERTIFICATION
Internal Medicine: 1981
Gastroenterology: 1985

Search again

Name ABIM ID NPI#

First (if known): SARKIS
Middle (if known): J
Last (required): CHOBANIAN
DOB (if known) mm/dd/yy format
Match Exactly | Show All
Is Similar | Show 20
Go

Check a physician's ABIM Board Certification status by searching name, ABIM ID or NPI# by using the verification tool (at top right).

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MOC Requirements
Annual Reverification Date – April 1st
Reporting Certification Status
Board Eligibility

THE

AMERICAN BOARD OF INTERNAL MEDICINE

INCORPORATED 1936

ATTESTS THAT

Charles Maurice O'Connor Jr

HAS MET THE REQUIREMENTS OF THIS BOARD AND IS HEREBY DESIGNATED A DIPLOMATE CERTIFIED IN THE SUBSPECIALTY OF

GASTROENTEROLOGY

FOR THE PERIOD 1991 THROUGH 2001

Emil E. Thomson — Stephen Goldfinger

Mark Feldman — William J. Snape Jr

Robert H. Rubin — Frank E. Silverstein

John P. Cello — J. Thomas Lamont — Michael F. Sorrell

121360

NOVEMBER 5, 1991

American Board of Internal Medicine®

Home | Search results for Name MEADE C EDMUNDS

Search results for Name MEADE C EDMUNDS

June 30, 2015

Edmunds, Meade C.

Gastroenterology: **Certified**

Participating in Maintenance of Certification: **Yes**

INITIAL CERTIFICATION
Internal Medicine: 1992
Gastroenterology: 1995

Search again

Name ABIM ID NPI#

First (if known): MEADE

Middle (if known): C

Last (required): EDMUNDS

DOB (if known) mm/dd/yy format

Match Exactly | Show All

Is Similar | Show 20 | Go

Check a physician's ABIM Board Certification status by searching name, ABIM ID or NPI# by using the verification tool (at top right).

Important information regarding the physician verification tool:

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For more information about ABIM certification and MOC, go to:

MOC Requirements
Annual Reverification Date – April 1st
Reporting Certification Status
Board Eligibility
Representation of Certification Status

American Board of Internal Medicine®

Home | Search results for Name JOHN M HAYDEK

Search results for Name JOHN M HAYDEK

June 30, 2015

Haydek, John M.

Gastroenterology: **Certified**
Internal Medicine: **Certified**

Participating in Maintenance of Certification: **Yes**

INITIAL CERTIFICATION
Internal Medicine: 1991
Gastroenterology: 1993

Search again

Name ABIM ID NPI#

First (if known): JOHN
Middle (if known): M
Last (required): HAYDEK
DOB (if known), mm/dd/yy format:
Match Exactly Show All
Is Similar Show 20
Go

Check a physician's ABIM Board Certification status by searching name, ABIM ID or NPI# by using the verification tool (at top right).

Important information regarding the physician verification tool:

- Most diplomates certified prior to 1990 are not required to participate in MOC but are strongly encouraged to do so.
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- ABIM's website serves as primary source verification.
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For more information about ABIM certification and MOC, go to:

MOC Requirements
Annual Reverification Date – April 1st
Reporting Certification Status
Board Eligibility

THE

AMERICAN BOARD OF INTERNAL MEDICINE

INCORPORATED 1936

ATTESTS THAT

Maria del Mar Bonet Newman

HAS MET THE REQUIREMENTS OF THIS BOARD AND IS HEREBY CERTIFIED FOR THE PERIOD 2001 THROUGH 2011 AS A DIPLOMATE IN

GASTROENTEROLOGY

Paul G. Ramsay
CHAIR
AMERICAN BOARD OF INTERNAL MEDICINE

Douglas P. Zipes
CHAIR-ELECT
AMERICAN BOARD OF INTERNAL MEDICINE

James A. Vaughan
SECRETARY-TREASURER
AMERICAN BOARD OF INTERNAL MEDICINE

Henry R. Wiesenberger
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NUMBER 179818

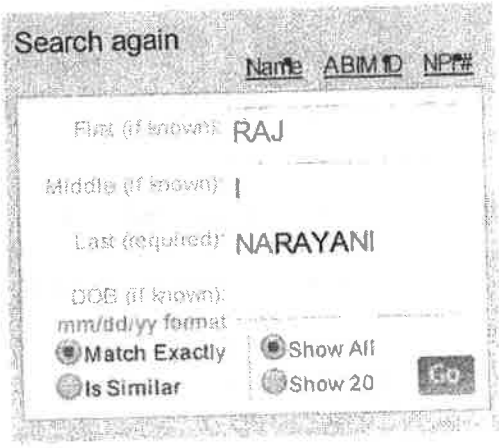
2001

106

American Board of Internal Medicine®

Home | Search results for Name RAJ I NARAYANI

Search results for Name RAJ I NARAYANI



June 30, 2015

Narayani, Raj I.

Gastroenterology: **Certified**
Internal Medicine: **Certified**

Participating in Maintenance of Certification: **Yes**

INITIAL CERTIFICATION
Internal Medicine: 1998
Gastroenterology: 2001

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Annual Reverification Date – April 1st
Reporting Certification Status
Board Eligibility

American Board of Internal Medicine®

Home | Search results for Name STEVEN J BINDRIM

Search results for Name STEVEN J BINDRIM

June 30, 2015

Bindrim, Steven J.

Gastroenterology: **Certified**

Participating in Maintenance of Certification: **Yes**

INITIAL CERTIFICATION
Internal Medicine: 1991
Gastroenterology: 1995

Search again

Name ABIM ID NPI#

First (if known): STEVEN
Middle (if known): J
Last (required): BINDRIM
DOB (if known) mm/dd/yy format
Match Exactly Is Similar
Show All Show 20
Go

Check a physician's ABIM Board Certification status by searching name, ABIM ID or NPI# by using the verification tool (at top right).

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For more information about ABIM certification and MOC, go to:

MOC Requirements
Annual Reverification Date – April 1st
Reporting Certification Status
Board Eligibility
Representation of Certification Status

American Board of Internal Medicine®

Home | Search results for Name SCOTT L WILHOITE

Search results for Name SCOTT L WILHOITE

June 30, 2015

Wilhoite, Scott L.

Gastroenterology: **Certified**

Participating in Maintenance of Certification: **Yes**

INITIAL CERTIFICATION
Internal Medicine: 1990
Gastroenterology: 1993

Search again

Name | ABIM ID | NPI#

First (if known): SCOTT

Middle (if known): L

Last (required): WILHOITE

DOB (if known) mm/dd/yy format

Match Exactly | Show All

Is Similar | Show 20

Go

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MOC Requirements
Annual Reverification Date – April 1st
Reporting Certification Status
Board Eligibility
Representation of Certification Status

American Board of Internal Medicine®

Home | Search results for Name JOHNNY ALTAWIL

Search results for Name JOHNNY ALTAWIL

June 30, 2015

Altawil, Johnny

Gastroenterology: **Certified**
Internal Medicine: **Certified**

Participating in Maintenance of Certification: **Yes**

INITIAL CERTIFICATION
Internal Medicine: 2010
Gastroenterology: 2013

Search again

Name ABIM ID NPI#

First (if known): JOHNNY

Middle (if known):

Last (required): ALTAWIL

DOB (if known): mm/dd/yy format

Match Exactly | Show All

Is Similar | Show 20 | GO

Check a physician's ABIM Board Certification status by searching name, ABIM ID or NPI# by using the verification tool (at top right).

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For more information about ABIM certification and MOC, go to:

MOC Requirements
Annual Reverification Date – April 1st
Reporting Certification Status
Board Eligibility

American Board of Internal Medicine®

Home | Search results for Name JOHN MATTHEW MOORE

Search results for Name JOHN MATTHEW MOORE

June 30, 2015

Moore, John M.

Gastroenterology: **Certified**
Internal Medicine: **Certified**

Participating in Maintenance of Certification: **Yes**

INITIAL CERTIFICATION
Internal Medicine: 2011
Gastroenterology: 2014

Search again

Name ABIM ID NPI#

First (if known): JOHN
Middle (if known): MATTHEW
Last (required): MOORE
DOB (if known): mm/dd/yy format
Match Exactly Show All
Is Similar Show 20
Go

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For more information about ABIM certification and MOC, go to:

MOC Requirements
Annual Reverification Date – April 1st
Reporting Certification Status
Board Eligibility

Anesthesia Associates of Knoxville, LLC
801 N. Weisgarber Road
Knoxville, TN 37909

To Whom It May Concern:

Anesthesia Associates of Knoxville, LLC (AAK), currently holds individual contracts with ten (10) Certified Registered Nurse Anesthetists. Additionally, Anesthesia Associates of Knoxville, LLC is under contract with The Endoscopy Center Knoxville, The Knoxville Endoscopy Center – West, and The Endoscopy Center North to provide anesthesia service utilizing one of the ten contracted providers each day of operation, for each room in operation. Anesthesia Associates of Knoxville, LLC is operating under full intent to continue provision of services to the above referenced ASTCs and will remain contracted with relevant US and Tennessee-based government payers including TennCare, Medicare, Medicaid, as well as others.

If additional information is needed, please contact Jeff Dew, Chief Executive Officer, Gastrointestinal Associates (single member owner of Anesthesia Associates of Knoxville, LLC), at jfdew@gihealthcare.com or (865) 558-0644.

Sincerely,

Jeff Dew
Chief Executive Officer
Gastrointestinal Associates, P.C.

Tennova™
Healthcare

9
April 4, 2013

Administrator
Gastrointestinal Associates, PC and The Endoscopy Center
801 Weisgarber Road, Suite 100
Knoxville, TN 37901

Re: Transfer Agreement

Dear Sir or Madam:

Enclosed are two (2) originals of a Transfer Agreements between Metro Knoxville HMA, LLC d/b/a Tennova Healthcare – Physicians Regional Medical Center and Gastrointestinal Associates, PC and The Endoscopy Center. Please review and obtain the appropriate signatures on behalf of Gastrointestinal Associates, PC and The Endoscopy Center and return the signed agreements to me for signature on behalf Metro Knoxville HMA, LLC d/b/a Tennova Healthcare – Physicians Regional Medical Center. I will then obtain those signatures and return one (1) fully executed original agreement to you for your file.

Thank you for your assistance with the completion of these agreements. If you have any questions, please call me at 865/545-7541.

Sincerely,

Deon Cabbage

Deon Cabbage
Executive Assistant

Encl.

PATIENT TRANSFER AGREEMENT

THIS PATIENT TRANSFER AGREEMENT ("Agreement") is made as of May 1, 2013, between Gastrointestinal Associates, PC and The Endoscopy Center ("Transferring Facility") and Metro Knoxville HMA, LLC d/b/a Tennova Healthcare - Physicians Regional Medical Center ("Receiving Facility").

WITNESSETH

WHEREAS, the parties desire to: facilitate the timely transfer of patients who require acute care inpatient hospital services ("Patients") as well as medical and other information necessary or useful in the care and treatment of the Patients;

WHEREAS, the parties desire to: expedite decisions as to the most appropriate provider of care for Patients; ensure them continuity of care and treatment required by Patients; and improve the professional health care provided to Patients by utilizing the knowledge and other resources of both parties in a coordinated and cooperative manner;

WHEREAS, Transferring Facility must arrange to transfer Patients to other facilities;

WHEREAS, the Receiving Facility has agreed to accept transfer of Patients under the terms set forth herein;

WHEREAS, the parties desire to supply a full statement of their agreement with respect to the provision of services during the term of this Agreement.

NOW, THEREFORE, the parties agree as follows:

1. Situations Justifying Transfer. When beds and staff are available and the applicable provisions of this Agreement are observed, Receiving Facility agrees to accept Patients in need of medical care that is not available at Transferring Facility. The procedure for transfer is as follows: Call 865/545-7573 and inform the Receiving Facility of the nature of the transfer.

2. Receiving Facility Agrees:
   A. To accept the transfer of Patients from Transferring Facility who meet admission criteria, subject to the availability of beds.
   B. To comply with all provisions of EMTALA and HIPAA/HITECH.
   C. That no emergency transfer will be delayed for financial reasons.

3. Transferring Facility Agrees:
   A. To identify Patients and to obtain Receiving Facility's acceptance of the transfer prior to transferring the patient.
   B. To obtain the Patient's consent to the transfer if the Patient is competent. If the Patient is not competent, Transferring Facility shall obtain a family member's consent; if such consent is not possible, the consent of the Patient's physician shall be obtained by Transferring Facility.

C. To work collaboratively with Receiving Facility to provide clinical information to ensure continuity of care in compliance with EMTALA regulations and insofar as confidentiality laws permit.
D. To comply with all provisions of EMTALA and HIPAA/HITECH.
E. To arrange for transportation from the Transferring Facility to Receiving Facility.

4. Patient Records and Personal Effects. Transferring Facility shall use standard forms to provide medical and administrative information to accompany the patient to Receiving Facility. The information shall include, when appropriate, the following:
   A. Patient's name, address, hospital number, age, and name, address and telephone number of next of kin if available;
   B. Patient's third party billing data;
   C. History of the illness;
   D. Condition on admission;
   E. Vital signs pre-hospital, during stay in the emergency department, and at the time of transfer;
   F. Treatment provided to patient, including medications given and route of administration;
   G. Laboratory and X-ray findings;
   H. Fluids given, type and volume;
   I. Name, address, and phone number of physician referring patient;

   Transferring Facility shall supplement the above information as necessary for the maintenance of the Patient during transport and as necessary for treatment upon arrival at Receiving Facility. In addition, the inventory of the Patient's personal effects and valuables shall accompany the patient during transfer. The records described above shall be placed in the custody of the person in charge of the transportation medium who shall sign a receipt for the medical records and the Patient's valuables and personal effects and shall in turn shall obtain a receipt from Receiving Facility when it provides the records and the Patient's valuables and personal effects to Receiving Facility.

5. Independent Contractor Status. Each of the institutions are independent contractors. Neither of the parties is authorized or permitted to act as an agent or employee of the other. Nothing in this Agreement shall in any way alter the freedom enjoyed by the parties, nor shall it in any way alter the control of the management, assets, and affairs of the respective parties. Neither party, by virtue of this Agreement, assumes any liability for any debts or obligations, of either a financial or legal nature, incurred by the other party to this Agreement.

6. Insurance. Each Party shall secure and maintain, or cause to be secured and maintained, during the term of this Agreement comprehensive general and professional liability insurance.

7. Renegotiation or Modification. Any alterations, variations, modification or waivers of any provision of this Agreement shall only be valid when they have been reduced to writing and duly signed. The parties agree to renegotiate this Agreement if there are changes to Federal and/or State law, regulations, or the interpretation thereof make amendments to this Agreement necessary in the judgment of either party.

8. Term and Termination.
   A. This agreement shall commence on May 1, 2013 and continue in effect until terminated by either party.
   B. Either party may terminate this Agreement or any part of this Agreement at any time, upon no less than 30 days notice in writing to the other party. Said notice shall be delivered by certified mail, facsimile transmission, or in person.

9. No Exclusion from Programs. Each party represents that neither it nor its employees are currently excluded from participating in any federal or state government-funded health care program.

10. Books and Records. The parties agree that to the extent this Agreement is subject to the provisions of Public Law 96-449, the Omnibus Reconciliation Act of 1980, they will make available all books and records with respect to the services provided to the extent required by law; and to the extent required by law, the provisions of Section 1395x(v)(1) of Title 42 of the United States Code are incorporated herein by reference with like effect as though set forth at length.

11. Governing Law. This Agreement is made and entered into in the State of Tennessee and shall be governed and construed in accordance with the laws of Tennessee.

12. Assignment. This Agreement shall not be assigned in whole or in part by either party hereto without the express written consent of the other party.

13. Invalid Provision. In the event that any portion of this Agreement shall be determined to be invalid or unenforceable, the remainder of this Agreement shall be deemed to continue to be binding upon the parties hereto in the same manner as if the invalid provision were not a part of this Agreement.

14. Notice. All notices required or permitted pursuant to this Agreement shall be in writing and delivered by certified U.S. mail, postage prepaid, return receipt requested, and shall be deemed effective two (2) business days after mailing, if addressed to the parties at the following addresses:

If to Transferring Facility: Gastrointestinal Associates, PC and The Endoscopy Center

801 Weisgarber Road, Suite 100
Knoxville, Tennessee 37901
Attn: Administrator

If to Receiving Facility: Metro Knoxville HMA, LLC d/b/a Tennessee Healthcare – Phyisicians Regional Medical Center
900 E. Oak Hill Avenue
Knoxville, Tennessee 37917
Attn: CEO

15. Binding Agreement. This Agreement shall be binding upon the successors or assigns of the parties hereto.

16. Authorization for Agreement. The execution by each party has been duly authorized by all necessary laws, resolutions, or corporate actions, and this Agreement contains the valid and enforceable obligations of each Party.

17. Headings. The headings to the various sections of this Agreement have been inserted for convenience only and shall not modify, define, limit or expand express provisions of this Agreement.

18. No Verbal Modifications. This Agreement may not be modified, amended, supplemented or waived except by written agreement, signed by the parties. No delay, omission or failure by a party to exercise any right, power or remedy to which a party may be entitled shall impair any other such right, power or remedy, nor shall such be construed as a release by a party of such right, power or remedy or as a waiver, unless set forth in a written agreement, signed by the parties. A waiver by a party of any right, power or remedy in any one instance shall not constitute a waiver of the same or any other right, power or remedy in any other instance.

IN WITNESS WHEREOF, Receiving Facility and Transferring Facility have hereunto caused this Agreement to be executed as by law provided, the day and year first above written.

Receiving Facility	Transferring Facility
Karen Metz	The Endoscopy Center
Signature	Signature
Karen Metz	Gayle Walker

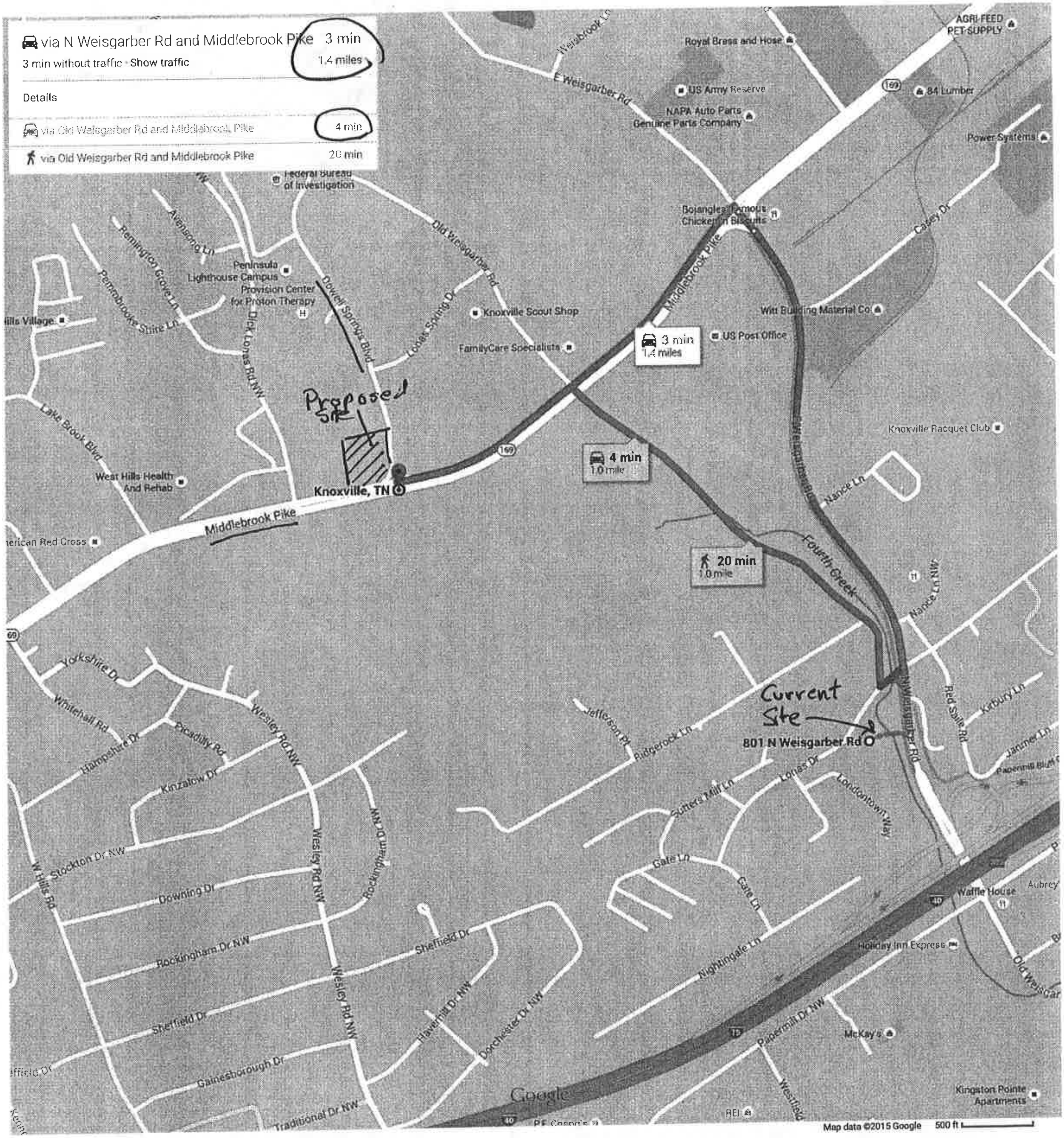
	Coryle Mahan
Printed Name	Printed Name
	Administrator
Title	Title

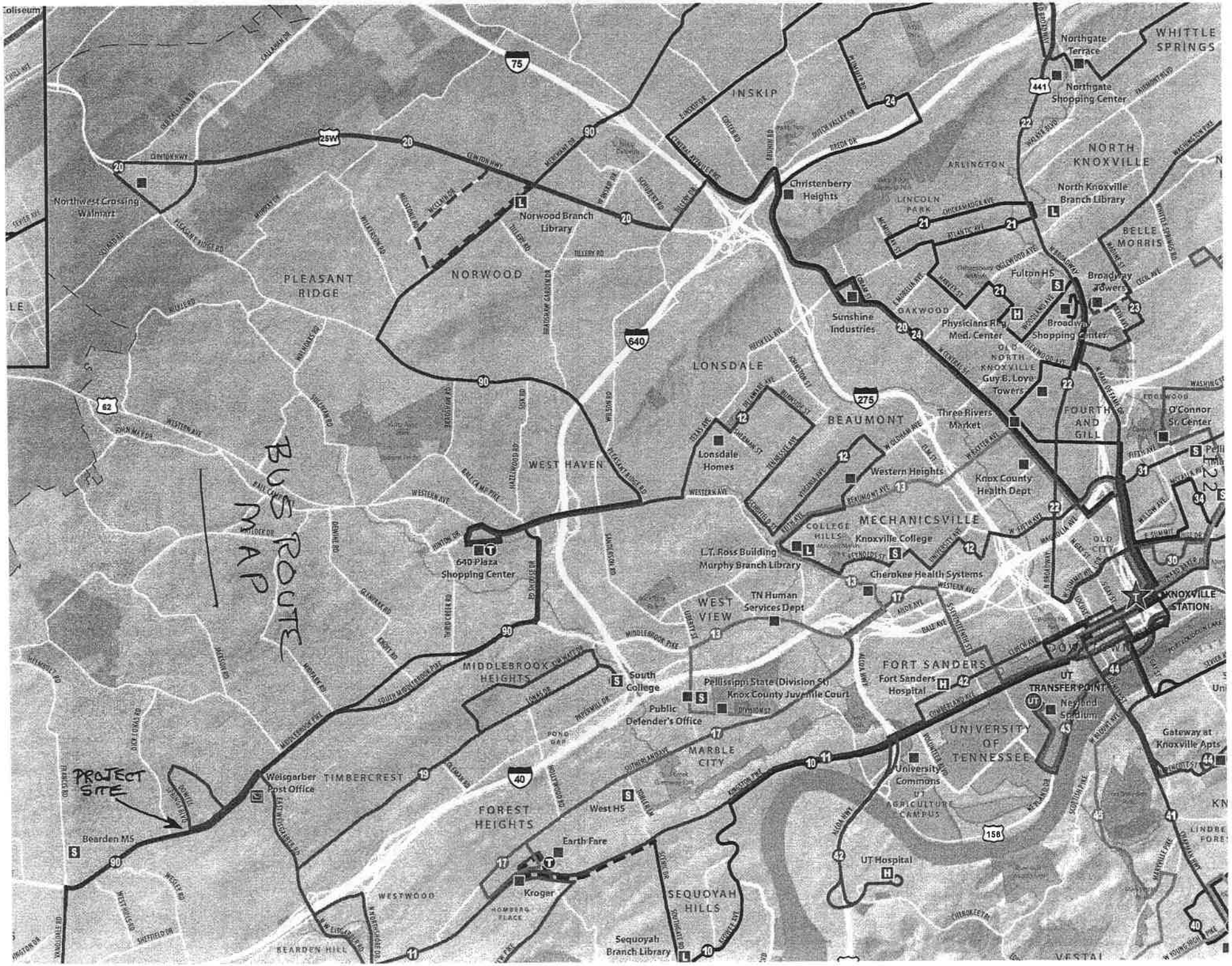
C, Need--3
Service Area Maps

Printable Maps From:
terproof Paper.com

THE ENDOSCOPY CENTER

PRIMARY SERVICE AREA


via N Weisgarber Rd and Middlebrook Pike 3 min
3 min without traffic · Show traffic 1.4 miles
Details
via Old Weisgarber Rd and Middlebrook Pike 4 min
via Old Weisgarber Rd and Middlebrook Pike 20 min
Proposed Site
Current Site
Knoxville, TN
801 N Weisgarber Rd
Middlebrook Pike
3 min
1.4 miles
4 min
1.0 mile
20 min
1.0 mile
Federal Bureau of Investigation
Peninsula Lighthouse Campus
Provision Center for Proton Therapy
Knoxville Scout Shop
FamilyCare Specialists
US Post Office
Witt Building Material Co
Bojangles' Famous Chicken 'n Biscuits
Royal Brass and Hose
US Army Reserve
NAPA Auto Parts Genuine Parts Company
AGRI-FEED PET SUPPLY
84 Lumber
Power Systems
Knoxville Racquet Club
West Hills Health And Rehab
Fourth Creek
Waffle House
Holiday Inn Express
McKay's
Kingston Pointe Apartments
REI
Map data ©2015 Google 500 ft


BUS ROUTE MAP
PROJECT SITE
Coliseum
Northwest Crossing Walmart
Norwood Branch Library
PLEASANT RIDGE
NORWOOD
INSKIP
Christenberry Heights
Northgate Terrace
Northgate Shopping Center
WHITTLE SPRINGS
ARLINGTON
NORTH KNOXVILLE
North Knoxville Branch Library
LINCOLN PARK
BELLE MORRIS
Fulton HS
Broadway Towers
Broadway Shopping Center
Sunshine Industries
OAKWOOD
Physicians Reg. Med. Center
OLD NORTH KNOXVILLE
Guy B. Love Towers
LONSDALE
BEAUMONT
Three Rivers Market
FOURTH AND GILL
O'Connor Sr. Center
Lonsdale Homes
WEST HAVEN
Western Heights
Knox County Health Dept
MECHANICSVILLE
COLLEGE HILLS
Knoxville College
L.T. Ross Building Murphy Branch Library
640 Plaza Shopping Center
Cherokee Health Systems
TN Human Services Dept
KNOXVILLE STATION
WEST VIEW
MIDDLEBROOK HEIGHTS
South College
Pellissippi State (Division St)
Knox County Juvenile Court
Public Defender's Office
FORT SANDERS
Fort Sanders Hospital
UT TRANSFER POINT
Neyland Stadium
UNIVERSITY OF TENNESSEE
Gateway at Knoxville Apts
MARBLE CITY
University Commons
UT AGRICULTURE CAMPUS
Weisgarber Post Office
TIMBERCREST
FOREST HEIGHTS
West HS
Earth Fare
Kroger
Bearden MS
WESTWOOD
SEQUOYAH HILLS
Sequoyah Branch Library
UT Hospital
BEARDEN HILL
VESTAL

C, Economic Feasibility--1
Documentation of Construction Cost Estimate

DIA
Design Innovation
ARCHITECTS + INTERIORS + PLANNING

August 6, 2015

Ms. Melanie Hill
Executive Director
State of Tennessee
Health Services and Development Agency
500 Deadrick Street, Suite 850
Nashville, TN 37243

Re: The **Endoscopy Center @ Dowell Springs – Knoxville, TN**:
Endoscopy Center Relocation – Verification of Estimated Construction Cost

DIA Project Number: 14075 File: F01 103

Dear Ms. Hill:

We have reviewed the construction cost developed for the endoscopy center relocation project for The Endoscopy Center to the Dowell Springs site in Knoxville, TN. The construction cost of $4,300,124.00 is for build-out of the interior space.

It is our professional opinion that the construction cost proposed is very adequate and consistent with historical data based on similar type projects. It is important to note, that our opinion is based on normal market conditions, price escalation, etc.

The project will be developed under the current codes and standards enforced by the State of Tennessee and the City of Knoxville as follows:

STATE OF TENNESSEE
2006 INTERNATIONAL BUILDING CODE
2006 INTERNATIONAL PLUMBING CODE
2006 INTERNATIONAL MECHANICAL CODE
2006 INTERNATIONAL GAS CODE
2006 NFPA 1, EXCLUDING NFPA 5000
2006 NFPA 101 LIFE SAFETY CODE
2005 NATIONAL ELECTRIC CODE
2002 NORTH CAROLINA ACCESSIBILITY CODE WITH 2004 AMENDMENTS
2010 AMERICANS WITH DISABILITIES ACT (ADA)
2010 AIA GUIDELINES FOR DESIGN AND CONSTRUCTION OF HEALTH CARE FACILITIES (FGI)
2007 ASHRAE HANDBOOK OF FUNDAMENTALS

CITY OF KNOXVILLE
2012 INTERNATIONAL BUILDING CODE
2012 INTERNATIONAL PLUMBING CODE
2012 INTERNATIONAL FIRE CODE W/ LOCAL AMENDMENTS
2012 INTERNATIONAL MECHANICAL CODE
2012 INTERNATIONAL GAS CODE
2011 NATIONAL ELECTRIC CODE
2012 NFPA 101 LIFE SAFETY CODE
2010 AIA GUIDELINES FOR DESIGN AND CONSTRUCTION OF HEALTH CARE FACILITIES (FGI)
2009 ICC/AMERICAN NATIONAL STANDARD (ANSI) A117.1
2010 AMERICANS WITH DISABILITIES ACT (ADA)
2012 INTERNATIONAL ENERGY CONSERVATION CODE (IECC)

Sincerely,
Design Innovation

Richard Norris, AIA
Senior Project Architect [TN License No. 00016433]

ec: Faris Eid; Greg Campbell; Brandy Williams, Design Innovation

C, Economic Feasibility--2
Documentation of Availability of Funding

AMSURG

1A Burton Hills Boulevard
Nashville, Tennessee 37215

PHONE 615.665.1283
TOLL FREE 800.945.2301
FAX 615.665.0755

www.amsurg.com

August 10, 2015

Melanie M. Hill, Executive Director
Tennessee Health Families Commission
Andrew Jackson State Office Building, Ninth Floor
500 Deaderick Street
Nashville, TN 37243

Dear Mrs. Hill:

The Endoscopy Center of Knoxville, L.P., is an existing single-specialty ASTC limited to endoscopy. AmSurg indirectly owns 51% of that limited partnership.

The facility is filing a Certificate of Need application to move to a new location in Knoxville. The actual capital cost of the project is estimated at approximately $6,883.000.

As Chief Financial Officer of AmSurg, I am writing to confirm that AmSurg Corp. will provide all of the required funding for the project in the form of a loan to the applicant LLC. The Certificate of Need application includes the company's financial statements documenting that sufficient cash reserves, operating income, and lines of credit exist to provide that funding.

Sincerely,

Claire Gulmi
Chief Financial Officer and Executive Vice President

C, Economic Feasibility--10
Financial Statements

E01 Balance Sheet Centers
Data as of APR 10, 2015 at 5:20 p.m.

2001 Knoxville GI

Balance Sheets
March 31, 2015

	Mar 2015	Feb 2015	Increase (Decrease)	Dec 2014	Increase (Decrease)
ASSETS					
Current assets:					
Cash and cash equivalents	411,667	406,634	5,033	533,662	(121,996)
Accounts receivable:					
Accounts receivable gross	2,011,151	1,766,830	244,321	2,298,483	(287,332)
Contractual allowance	(1,143,016)	(995,020)	(147,996)	(1,386,043)	243,027
Bad debt allowance	(120,482)	(112,668)	(7,814)	(92,751)	(27,731)
Accounts receivable, net	747,653	659,142	88,510	819,689	(72,036)
Other receivables	45,885	30,382	15,503	39,039	6,846
Supplies inventory	100,604	100,604	0	100,604	0
Prepaid and other current assets	24,785	24,043	742	43,482	(18,697)
Total current assets	1,330,593	1,220,805	109,788	1,536,475	(205,882)
Property and equipment:					
Building improvements	1,244,784	1,244,784	0	1,244,784	0
Equipment	3,601,973	3,585,246	16,726	3,585,246	16,726
	4,846,756	4,830,030	16,726	4,830,030	16,726
Accumulated depreciation	(4,033,292)	(4,008,963)	(24,328)	(3,968,186)	(65,106)
Property and equipment, net	813,465	821,067	(7,602)	861,844	(48,379)
Intangible assets:					
Goodwill, net	4,199,118	4,199,118	0	4,199,118	0
Other intangibles	47,997	49,357	(1,361)	52,078	(4,082)
Intangible assets, net	4,247,114	4,248,475	(1,361)	4,251,196	(4,082)
Total assets	6,391,172	6,290,346	100,826	6,649,515	(258,343)
LIABILITIES AND EQUITY					
Current liabilities:					
Accounts payable	228,833	255,159	(26,326)	284,134	(55,300)
Current income taxes payable	36,725	22,376	14,348	9,901	26,824
Accrued salaries and benefits	253,381	210,276	43,104	204,526	48,854
Other accrued liabilities	12,399	8,729	3,670	0	12,399
Intercompany payable (receivable)	4,969	6,848	(1,878)	4,279	690
	536,306	503,388	32,919	502,839	33,467
Other long-term liabilities	165,261	165,350	(88)	165,526	(264)
Equity:					
GP capital account	2,901,698	2,867,021	34,678	3,050,387	(148,688)
LP capital account	2,787,906	2,754,588	33,318	2,930,763	(142,858)
Total equity	5,689,604	5,621,609	67,995	5,981,150	(291,546)
Total liabilities and equity	6,391,172	6,290,346	100,826	6,649,515	(258,343)

E02 IS Centers
Data as of APR 10, 2015 at 5:20 p.m.

2001-001 Knoxville GI

Statement of Earnings
For the Period Ending March 31, 2015

	Monthly Actual	Monthly Budget	Prior Month	YTD Actual	YTD Budget	YTD Prior Year
Gross charges:						
GI revenue	1,557,928	1,396,629	1,141,633	4,167,666	3,886,272	4,036,617
Total gross charges	1,557,928	1,396,629	1,141,633	4,167,666	3,886,272	4,036,617
Estimated reserves:						
Contractual adjustments	1,071,897	961,368	805,993	2,914,691	2,675,111	2,741,485
Bad debt expense	10,905	18,156	7,991	29,174	50,521	98,256
Total estimated adjustments	1,082,802	979,524	813,984	2,943,865	2,725,632	2,839,742
Net revenue	475,125	417,105	327,649	1,223,801	1,160,640	1,196,875
Operating expenses:						
Salaries and benefits	217,032	209,456	187,417	589,782	628,369	686,327
Medical supplies and drugs	44,254	34,535	40,965	122,713	96,097	95,036
Other variable expenses	53,336	64,020	68,111	168,887	190,246	219,533
Fixed expenses	21,010	21,803	21,262	63,654	65,409	63,688
Operating taxes	3,003	3,272	3,049	9,070	9,816	10,042
Depreciation	16,626	16,579	16,738	50,445	50,279	58,527
Total operating expenses	355,261	349,665	337,541	1,004,551	1,040,216	1,133,153
Operating income	119,864	67,440	(9,892)	219,250	120,424	63,723
Other income and (expense):						
Interest expense, net	37	41	0	41	123	(1,065)
Fees and other	471	339	913	1,707	1,017	594
Earnings before income taxes	120,372	67,820	(8,979)	220,999	121,564	63,252
Income tax expense	14,348	10,023	662	26,824	25,171	18,398
Net earnings	106,024	57,797	(9,640)	194,174	96,393	44,854

E01 Balance Sheet Centers
Data as of MAY 26, 2015 at 8:36 a.m.

2001 Knoxville GI

Balance Sheets
December 31, 2014

	Dec 2014	Nov 2014	Increase (Decrease)	Dec 2013	Increase (Decrease)
ASSETS					
Current assets:					
Cash and cash equivalents	533,662	485,924	47,739	310,859	222,804
Accounts receivable:					
Accounts receivable gross	2,298,483	1,981,154	317,329	2,031,102	267,381
Contractual allowance	(1,386,043)	(1,138,568)	(247,475)	(1,063,546)	(322,497)
Bad debt allowance	(92,751)	(66,844)	(25,907)	(143,767)	51,016
Accounts receivable, net	819,689	775,741	43,948	823,789	(4,100)
Other receivables	39,039	22,947	16,091	22,963	16,075
Supplies inventory	100,604	109,632	(9,028)	109,632	(9,028)
Prepaid and other current assets	43,482	40,586	2,896	40,946	2,536
Total current assets	1,536,475	1,434,830	101,645	1,308,188	228,287
Property and equipment:					
Building improvements	1,244,784	1,244,784	0	1,244,784	0
Equipment	3,585,246	3,563,580	21,666	3,512,734	72,512
	4,830,030	4,808,364	21,666	4,757,518	72,512
Accumulated depreciation	(3,968,186)	(3,945,312)	(22,873)	(3,695,632)	(272,553)
Property and equipment, net	861,844	863,051	(1,207)	1,061,885	(200,041)
Intangible assets:					
Goodwill, net	4,199,118	4,199,118	0	4,199,118	0
Other intangibles	52,078	45,249	6,829	59,862	(7,783)
Intangible assets, net	4,251,196	4,244,367	6,829	4,258,979	(7,783)
Total assets	6,649,515	6,542,248	107,267	6,629,052	20,463
LIABILITIES AND EQUITY					
Current liabilities:					
Accounts payable	284,134	285,870	(1,736)	236,263	47,871
Current income taxes payable	9,901	27,185	(17,285)	2,749	7,152
Accrued salaries and benefits	204,526	165,914	38,612	226,494	(21,968)
Other accrued liabilities	0	1,624	(1,624)	0	0
Intercompany payable (receivable)	4,279	7,391	(3,112)	5,398	(1,119)
	502,839	487,985	14,854	470,904	31,936
Long-term debt	0	0	0	149,556	(149,556)
Other long-term liabilities	165,526	165,614	(88)	162,942	2,584
Equity:					
GP capital account	3,050,387	3,003,212	47,175	2,981,282	69,105
LP capital account	2,930,763	2,885,438	45,325	2,864,369	66,395
Total equity	5,981,150	5,888,650	92,501	5,845,651	135,500
Total liabilities and equity	6,649,515	6,542,248	107,267	6,629,052	20,463

E02 IS Centers
Data as of MAY 26, 2015 at 8:36 a.m.

2001-001 Knoxville GI

Statement of Earnings
For the Period Ending December 31, 2014

	Monthly Actual	Monthly Budget	Prior Month	YTD Actual	YTD Budget	YTD Prior Year
Gross charges:						
GI revenue	1,800,484	1,454,002	1,397,248	17,454,957	17,136,013	20,400,296
Total gross charges	1,800,484	1,454,002	1,397,248	17,454,957	17,136,013	20,400,296
Estimated reserves:						
Contractual adjustments	1,243,137	1,002,480	983,485	12,064,650	11,809,853	14,100,654
Bad debt expense	12,603	11,632	9,781	217,185	137,089	192,802
Total estimated adjustments	1,255,740	1,014,112	993,266	12,281,835	11,946,942	14,293,456
Net revenue	544,744	439,890	403,983	5,173,122	5,189,071	6,106,840
Operating expenses:						
Salaries and benefits	221,587	241,351	175,401	2,407,309	2,896,212	2,878,240
Medical supplies and drugs	49,156	41,359	37,318	480,012	487,432	581,418
Other variable expenses	61,306	65,850	52,545	731,500	853,200	836,271
Fixed expenses	22,248	22,928	20,052	250,278	274,623	261,947
Operating taxes	2,023	3,220	1,430	36,022	38,640	39,701
Depreciation	19,891	18,671	19,172	231,163	227,312	238,173
Total operating expenses	376,211	393,379	305,919	4,136,283	4,777,419	4,835,750
Operating income	168,533	46,511	98,064	1,036,839	411,652	1,271,091
Other income and (expense):						
Interest expense, net	68	7	0	(1,867)	(2,230)	(8,082)
Fees and other	323	279	94	4,378	3,348	5,304
Earnings before income taxes	168,924	46,797	98,159	1,039,349	412,770	1,268,312
Income tax expense	18,214	11,875	14,420	138,342	97,859	146,418
Net earnings	150,710	34,922	83,738	901,007	314,911	1,121,894

AMSURG

ANNUAL REPORT 2014

Management's Discussion and Analysis of Financial Condition and Results of Operations - (continued)

Ambulatory Services Operations

The following table presents the number of procedures performed at our continuing centers and changes in the number of ASCs in operation, under development and under letter of intent for the years ended December 31, 2014, 2013 and 2012. An ASC is deemed to be under development when a LP or LLC has been formed with the physician partners to develop the ASC.

Procedures	2014	2013	2012
Centers in operation, end of period (consolidated)	1,645,350	1,609,761	1,478,888
Centers in operation, end of period (unconsolidated)	237	233	229
Average number of continuing centers in operation, during period	9	3	2
New centers added, during period	233	230	216
Centers discontinued, during period	10	6	18
Centers under development, end of period	6	3	4
Centers under letter of intent, end of period	2	—	—
	5	5	2

Of the continuing centers in operation at December 31, 2014, 150 centers performed gastrointestinal endoscopy procedures, 51 centers performed procedures in multiple specialties, 37 centers performed ophthalmology procedures and 8 centers performed orthopaedic procedures.

A significant measurement of how much our ambulatory services revenues grow from year to year for existing centers is our ambulatory services same-center revenue percentage. We define our same-center group each year as those centers that contain full year-to-date operations in both comparable reporting periods, including the expansion of the number of operating centers associated with a LP or LLC. Ambulatory services revenues at our 2014 same-center group, comprising 224 centers and constituting approximately 91% of our total number of consolidated centers, increased by 0.7% during the year ended December 31, 2014 compared to the prior period.

The following table presents selected statement of earnings data expressed in dollars (in thousands) and as a percentage of net revenue for our ambulatory services segment.

	For the Year Ended December 31,					
	2014		2013		2012	
Net revenue	$ 1,109,935	100.0%	$ 1,057,196	100.0%	$ 899,245	100.0%
Operating expenses:						
Salaries and benefits	341,906	30.8	327,585	31.0	284,528	31.6
Supply cost	163,004	14.7	153,126	14.5	126,919	14.1
Other operating expenses	230,307	20.7	216,501	20.5	185,866	20.7
Transaction costs	29,004	2.6	300	—	700	0.1
Depreciation and amortization	34,667	3.1	32,400	3.1	29,255	3.3
Total operating expenses	798,888	72.0	729,912	69.0	627,268	69.8
Gain on deconsolidation	3,411	0.3	2,237	0.2	—	—
Equity in earnings of unconsolidated affiliates	3,199	0.3	3,151	0.3	1,564	0.2
Operating income	$ 317,657	28.6%	$ 332,672	31.5%	$ 273,541	30.4%

Financial Statements and Supplementary Data - (continued)

AmSurg Corp.
Consolidated Balance Sheets
(In thousands)

	December 31, 2014	December 31, 2013
Assets		
Current assets:		
Cash and cash equivalents	$ 208,079	$ 50,840
Restricted cash and marketable securities	10,219	—
Accounts receivable, net of allowance of $113,357 and $27,862, respectively	233,053	105,072
Supplies inventory	19,974	18,414
Prepaid and other current assets	115,362	36,699
Total current assets	586,687	211,025
Property and equipment, net	180,448	163,690
Investments in unconsolidated affiliates	75,475	15,526
Goodwill	3,381,149	1,758,970
Intangible assets, net	1,273,879	27,867
Other assets	25,886	866
Total assets	$ 5,523,524	$ 2,177,944
Liabilities and Equity		
Current liabilities:		
Current portion of long-term debt	$ 18,826	$ 20,844
Accounts payable	29,585	27,501
Accrued salaries and benefits	140,044	32,294
Accrued interest	29,644	1,885
Other accrued liabilities	67,986	7,346
Total current liabilities	286,085	89,870
Long-term debt	2,232,186	583,298
Deferred income taxes	633,480	176,020
Other long-term liabilities	89,443	25,503
Commitments and contingencies		
Noncontrolling interests – redeemable	184,099	177,697
Equity:		
Mandatory convertible preferred stock, no par value, 5,000 shares authorized, 1,725 and 0 shares issued and outstanding, respectively	166,632	—
Common stock, no par value, 70,000 shares authorized, 48,113 and 32,353 shares outstanding, respectively	885,393	185,873
Retained earnings	627,522	578,324
Total AmSurg Corp. equity	1,679,547	764,197
Noncontrolling interests – non-redeemable	418,684	361,359
Total equity	2,098,231	1,125,556
Total liabilities and equity	$ 5,523,524	$ 2,177,944

See accompanying notes to the consolidated financial statements.

Financial Statements and Supplementary Data - (continued)

AmSurg Corp.
Consolidated Statements of Earnings
(In thousands, except earnings per share)

	Year Ended December 31,		
	2014	2013	2012
Revenues	$ 1,738,950	$ 1,057,196	$ 899,245
Provision for uncollectibles	(117,001)	—	—
Net revenues	1,621,949	1,057,196	899,245
Operating expenses:			
Salaries and benefits	694,576	327,585	284,528
Supply cost	164,296	153,126	126,919
Other operating expenses	284,928	216,501	185,866
Transaction costs	33,890	300	700
Depreciation and amortization	60,344	32,400	29,255
Total operating expenses	1,238,034	729,912	627,268
Gain on deconsolidation	3,411	2,237	—
Equity in earnings of unconsolidated affiliates	7,038	3,151	1,564
Operating income	394,364	332,672	273,541
Interest expense, net	83,285	29,525	16,950
Debt extinguishment costs	16,887	—	—
Earnings from continuing operations before income taxes	294,192	303,147	256,591
Income tax expense	48,103	48,654	40,893
Net earnings from continuing operations	246,089	254,493	215,698
Net earnings (loss) from discontinued operations	(1,296)	7,051	7,945
Net earnings	244,793	261,544	223,643
Less net earnings attributable to noncontrolling interests	191,092	188,841	161,080
Net earnings attributable to AmSurg Corp. shareholders	53,701	72,703	62,563
Preferred stock dividends	(4,503)	—	—
Net earnings attributable to AmSurg Corp. common shareholders	$ 49,198	$ 72,703	$ 62,563
Amounts attributable to AmSurg Corp. common shareholders:			
Earnings from continuing operations, net of income tax	$ 50,777	$ 71,009	$ 60,037
Earnings (loss) from discontinued operations, net of income tax	(1,579)	1,694	2,526
Net earnings attributable to AmSurg Corp. common shareholders	$ 49,198	$ 72,703	$ 62,563
Basic earnings per share attributable to AmSurg Corp. common shareholders:			
Net earnings from continuing operations	$ 1.29	$ 2.27	$ 1.95
Net earnings (loss) from discontinued operations	(0.04)	0.05	0.08
Net earnings	$ 1.25	$ 2.32	$ 2.03
Diluted earnings per share attributable to AmSurg Corp. common shareholders:			
Net earnings from continuing operations	$ 1.28	$ 2.22	$ 1.90
Net earnings (loss) from discontinued operations	(0.04)	0.05	0.08
Net earnings	$ 1.24	$ 2.28	$ 1.98
Weighted average number of shares and share equivalents outstanding:			
Basic	39,311	31,338	30,773
Diluted	39,625	31,954	31,608

See accompanying notes to the consolidated financial statements.

Financial Statements and Supplementary Data - (continued)

AmSurg Corp.
Consolidated Statements of Changes in Equity
(In thousands)

	AmSurg Corp. Shareholders					Noncontrolling Interests – Non-Redeemable	Total Equity (Permanent)	Noncontrolling Interests – Redeemable (Temporary Equity)
	Common Stock		Mandatory Convertible Preferred Stock		Retained Earnings			
	Shares	Amount	Shares	Amount				
Balance at January 1, 2012	31,284	$ 173,187	—	$ —	$ 443,058	$ 132,222	$ 748,467	$ 170,636
Net earnings	—	—	—	—	62,563	26,303	88,866	134,777
Issuance of restricted stock	281	—	—	—	—	—	—	—
Cancellation of restricted stock	(2)	—	—	—	—	—	—	—
Stock options exercised	842	18,214	—	—	—	—	18,214	—
Stock repurchased	(464)	(13,101)	—	—	—	—	(13,101)	—
Share-based compensation	—	6,692	—	—	—	—	6,692	—
Tax benefit related to exercise of stock	—	1,834	—	—	—	—	1,834	—
Distributions to noncontrolling interests, net of capital contributions	—	—	—	—	—	(26,514)	(26,514)	(136,356)
Acquisitions and other transactions impacting noncontrolling interests	—	252	—	—	—	174,615	174,867	6,957
Disposals and other transactions impacting noncontrolling interests	—	(3,211)	—	—	—	4,352	1,141	(632)
Balance at December 31, 2012	31,941	$ 183,867	—	$ —	$ 505,621	$ 310,978	$ 1,000,466	$ 175,382
Net earnings	—	—	—	—	72,703	49,789	122,492	139,052
Issuance of restricted stock	292	—	—	—	—	—	—	—
Cancellation of restricted stock	(16)	—	—	—	—	—	—	—
Stock options exercised	1,393	33,349	—	—	—	—	33,349	—
Stock repurchased	(1,257)	(45,964)	—	—	—	—	(45,964)	—
Share-based compensation	—	8,321	—	—	—	—	8,321	—
Tax benefit related to exercise of stock	—	7,247	—	—	—	—	7,247	—
Distributions to noncontrolling interests, net of capital contributions	—	—	—	—	—	(49,533)	(49,533)	(134,298)
Acquisitions and other transactions impacting noncontrolling interests	—	679	—	—	—	48,115	48,794	(319)
Disposals and other transactions impacting noncontrolling interests	—	(1,626)	—	—	—	2,010	384	(2,120)
Balance at December 31, 2013	32,353	$ 185,873	—	$ —	$ 578,324	$ 361,359	$ 1,125,556	$ 177,697
Net earnings	—	—	—	—	53,701	56,048	109,749	135,044
Issuance of stock	15,490	693,289	1,725	166,632	—	—	859,921	—
Issuance of restricted stock	272	—	—	—	—	—	—	—
Cancellation of restricted stock	(12)	—	—	—	—	—	—	—
Stock options exercised	111	2,630	—	—	—	—	2,630	—
Stock repurchased	(101)	(4,615)	—	—	—	—	(4,615)	—
Share-based compensation	—	10,104	—	—	—	—	10,104	—
Tax benefit related to exercise of stock	—	3,177	—	—	—	—	3,177	—
Dividends paid on preferred stock	—	—	—	—	(4,503)	—	(4,503)	—
Distributions to noncontrolling interests, net of capital contributions	—	—	—	—	—	(56,439)	(56,439)	(133,594)
Acquisitions and other transactions impacting noncontrolling interests	—	744	—	—	—	54,725	55,469	6,482
Disposals and other transactions impacting noncontrolling interests	—	(5,809)	—	—	—	2,991	(2,818)	(1,530)
Balance at December 31, 2014	48,113	$ 885,393	1,725	$ 166,632	$ 627,522	$ 418,684	$ 2,098,231	$ 184,099

See accompanying notes to the consolidated financial statements.

C, Orderly Development--7(C)
Licensing & Accreditation Inspections

Board for Licensing Health Care Facilities

State of Tennessee License No. 0000000024

DEPARTMENT OF HEALTH

This is to certify, that a license is hereby granted by the State Department of Health to

THE ENDOSCOPY CENTER OF KNOXVILLE, L.P. *to conduct and maintain*

an Ambulatory Surgical Treatment Center THE ENDOSCOPY CENTER

Located at 801 WEISGARBER ROAD, STE 100, KNOXVILLE

County of KNOX *, Tennessee.*

This license shall expire MAY 05 *,* 2016 *, and is subject to the provisions of Chapter 11, Tennessee Code Annotated. This license shall not be assignable or transferable, and shall be subject to revocation at any time by the State Department of Health, for failure to comply with the laws of the State of Tennessee or the rules and regulations of the State Department of Health issued thereunder.*

In Witness Whereof, we have hereunto set our hand and seal of the State this 5TH *day of* MAY *,* 2015

In the Specialty(ies) of: GASTROENTEROLOGY

139

AUG 14 '15 PM1:49

By Vincent J. Dawson, MPH

DIRECTOR, DIVISION OF HEALTH CARE FACILITIES

By

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
OFFICE OF HEALTH LICENSURE AND REGULATION
EAST TENNESSEE REGION
5904 LYONS VIEW PIKE, BLDG. 1
KNOXVILLE, TENNESSEE 37919

July 09, 2012

Ms. Gale Mahan, RN, Administrator
The Endoscopy Center
801 Weisgarber Rd
Knoxville TN 37950

RE: 44C0001014

Dear Ms. Mahan:

The East Tennessee Region of Health Care Facilities conducted your annual recertification survey on April 3-4, 2012. An on-site revisit was conducted on May 3 and June 21, 2012. Based on the on-site revisit on May 3 and June 21, 2012 and review of your plan of correction, we are accepting your plan of correction and your facility is in compliance with all participation requirements as of May 19, 2012

If you have any questions, please contact the East Tennessee Regional Office by phone: 865-588-5656 or by fax: 865-594-5789.

Sincerely,

Karen B Kirby | kg

Karen B. Kirby, RN
Regional Administrator
East TN Health Care Facilities

KK: kg

TN000

Completed copy
to CMS
4/17/12

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
OFFICE OF HEALTH LICENSURE AND REGULATION
EAST TENNESSEE REGION
5904 LYONS VIEW PIKE, BLDG. 1
KNOXVILLE, TENNESSEE 37919

April 11, 2012

Ms. Gayle Mahan, R.N., Administrator
The Endoscopy Center
801 Weisgarber Road, Suite 100
Knoxville, TN 37909

Dear Ms. Mahan:

Enclosed is the Statement of Deficiencies, which was developed as a result of the recertification survey, conducted at your facility on April 4, 2012. You are requested to submit a Credible Allegation of Compliance within **ten (10) days after receipt of this letter with acceptable time frames for correction of the cited deficiencies. Corrective action must be achieved no later than May 19, 2012, (45 days from the date of the survey).** Please notify this office when these deficiencies are corrected. A revisit must be conducted prior to the forty-fifth day to verify compliance. Once corrective action is confirmed, a favorable recommendation for re-certification will be considered.

The following one (1) condition level deficiency was cited for noncompliance:
Q 001 416.25 Basic Requirements

The following standard level deficiencies were cited for noncompliance:
Q 002, Q 101, Q 105, Q 181, Q223, Q 242

Based on noncompliance with the aforementioned Condition and Standard Level Deficiencies, this office is recommending to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated if substantial compliance is not achieved. Please be advised that under the disclosure of survey information provisions, the Statement of Deficiencies will be available to the public.

Your plan of correction must contain the following:

- How the deficiency will be corrected;
- How the facility will prevent the same deficiency from recurring.
- The date the deficiency will be corrected;
- How ongoing compliance will be monitored.

If there are any delays in completing your Plan of Correction, please notify this office in writing. After the Plan of Correction has been received by our office and has been reviewed and found to be acceptable, you will not be receiving notice of the acceptance; however, if the Plan of Correction is unacceptable we will be in contact with you. Before the plan can be considered "acceptable," **it must be signed and dated by the administrator**

Should you have questions or if there is any way this office may be of assistance, please do not hesitate to call our office at 865-588-5656.

Sincerely,

Karen B. Kirby /mad

Karen B. Kirby, R.N.
Regional Administrator
East TN Health Care Facilities

KBKcvb

Enclosure

PRINTED: 04/05/2012
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	44C0001014	A. BUILDING _____ B. WING _____	04/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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Q 000	INITIAL COMMENTS During the recertification survey conducted on February 14 - 15, 2012 the facility was found not in compliance with Requirement 416.25 Condition of Coverage, Basic Requirements. Please Refer to Q002	Q 000		
Q 001	416.25 BASIC REQUIREMENTS Participation as an ASC is limited to facilities that- (a) Meet the definition in §416.2; and (b) Have in effect an agreement obtained in accordance with this subpart. This CONDITION is not met as evidenced by: Based on observation and interview, the facility failed to ensure the Ambulatory Surgery Center operated for the exclusive purpose of providing out-patient surgical services as a distinct entity. The facility was cited for the Condition of Coverage for Basic Requirements for failing to ensure common space and services were not shared during overlapping hours of operation of the Ambulatory Surgery Center and a physician's office practice. The findings included: Please refer to Q002	Q 001	**Q 001 416.26 BASIC REQUIREMENTS** Plan of Correction The Endoscopy Center will ensure sharing of common spaces will only occur when the Physician office is closed. Systemic Changes The physician office will be closed daily from 6:30AM to 11AM Monday through Friday. The Endoscopy Center will be operational during those same hours Monday through Friday. All Endoscopy Center patients will be received and taken into the space designated as Endoscopy Center prior to the arrival of office patients. Discharging of Endoscopy Center patients will occur through the Endoscopy Center discharge area to avoid overlap utilization of the registration area. This will begin on 05-01-2012.	
Q 002	416.2 DEFINITIONS As used in this part: Ambulatory surgical center or ASC means any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization and in which the expected duration of services would not exceed 24 hours following an admission. The entity must	Q 002	Cont	

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ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

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Q 002	416.2 DEFINITIONS As used in this part: Ambulatory surgical center or ASC means any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization and in which the expected duration of services would not exceed 24 hours following an admission. The entity must	Q 002		

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Q 002	Continued From page 1 have an agreement with CMS to participate in Medicare as an ASC, and must meet the conditions set forth in subparts B and C of this part.The ambulatory surgical center must comply with state licensure requirements. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the Ambulatory Surgery Center operated for the exclusive purpose of providing out-patient surgical services as a distinct entity. The facility failed to ensure common space and services were not shared during overlapping hours of operation of the Ambulatory Surgery Center and the physician's office practices. The findings included: Observation on April 3, 2012, at 8:00 a.m., of the entry to the Ambulatory Surgery Center revealed a single door with the name of the Surgery Center and the name of the office practice listed. Continued observation revealed one large lobby. Continued observation revealed a receptionist window on the right upon entry to the lobby. Continued observation revealed a sign on the receptionist window indicating for patients to sign in upon entry. Continued observation revealed the patients for the Ambulatory Surgery Center and the office practice were seated in the main lobby and called for procedures and office visits within the same hearing area of all in the lobby. Interview on April 3, 2012, at 2:40 p.m., in the physician's office nursing station with Registered	Q 002	**Q 002 416.2 DEFINITIONS** Plan of Correction The Endoscopy Center will ensure sharing of common spaces will only occur when the Physician office is closed. Systemic Changes The physician office will be closed daily from 6:30AM to 11AM Monday through Friday. The Endoscopy Center will be operational during those same hours Monday through Friday. All Endoscopy Center patients will be received and taken into the space designated as Endoscopy Center prior to the arrival of office patients. Discharging of Endoscopy Center patients will occur through the Endoscopy Center discharge area to avoid overlap utilization of the registration area. This will begin on 05-01-2012.	

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Q 002	Continued From page 2 Nurse (RN) #4 confirmed the RN would escort the surgery center patients to the physician's clinic exam room and review medical information. Continued interview confirmed the patient would then be escorted thru a door to the Ambulatory Surgery Center "Waiting Area". Interview in the Laboratory with the Laboratory Assistant on April 3, 2012, at 2:00 p.m., revealed "...the Surgery Center patients utilized the lab at the same time as the office patients..." Interview in the office of the Administrator with the Administrator on April 4, 2012, at 8:20 a.m., confirmed there was no clear and distinct separation of space for patients presenting for a procedure at the Ambulatory Surgery Center and patients arriving for appointments at the physician's office practice. Continued interview confirmed the Ambulatory Surgery Center patients shared the same lobby space at the same time as the physician's office practice patients. Continued interview confirmed the surgery center patients received initial review of medical history and status in the exam room of the physician's office practice before actually entering the Ambulatory Surgery Center. Continued interview confirmed there was no separation of lab usage for the surgery center patients and the physician office patients. Continued interview confirmed the laboratory is located in the physician's office area of the building.	Q 002	Responsible Party and Monitoring The Center Administrator or designee will ensure all physicians and staff are educated to the required process changes. The Center Administrator or designee will monitor activity daily for the next 90 days to ensure there are no breeches. If 100% compliance is not obtained, action plans will be modified and the study will continue until 100% compliance is achieved for one consecutive period of 90 days is achieved. Staff will be advised any future breeches must be reported to the Center Administrator for review and appropriate actions. Results of all monitors will be reported at the regularly scheduled QAPI meetings for reporting to the Governing Body. Comit	
Q 101	416.44(a)(1) PHYSICIAL ENVIRONMENT The ASC must provide a functional and sanitary environment for the provision of surgical services. Each operating room must be designed and	Q 101		

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Q 101	Continued From page 3 equipped so that the types of surgery conducted can be performed in a manner that protects the lives and assures the physical safety of all individuals in the area. This STANDARD is not met as evidenced by: Observation with the Administrator in procedure room #1 on April 3, 2012, at 2:30 p.m., revealed 20 culture swabs with an expiration date of July 2011. Interview with the Administrator in procedure room #1 on April 3, 2012, 2:30 p.m., confirmed the culture swabs were expired and available for patient use. Observation on April 3, 2012, during the facility tour, between 1:00 p.m. and 3:00 p.m., in the Endoscopy procedure room 7, revealed nine thin prep CytoLyt specimen bottles in the cabinet with an expiration date of October 2010. Interview with the Unit Manager and the facility administrator, in the procedure room, confirmed the specimen bottles were expired and available for use.	Q 101	**Q101 416.44(a)(1) PHYSICAL ENVIRONMENT** Plan of Correction Expired items will be removed from patient care areas and will not be available for patient use. Systemic Changes Expired items have been discarded. All cabinets and drawers in patient care areas have been searched and all expired items removed. The unit manager will inservice all procedure room assistants on _____with regard to their responsibility to monitor all supplies in the room on a weekly basis. A list of supplies will be maintained in each procedure room. (See attached supply list) This list will be monitored weekly by the procedure room assistant and documented with date and signature. The unit manager will verify the completion of the weekly checks on a monthly basis. Responsible Party and Monitoring The unit manager or designee is responsible for developing a procedure room supply list. The unit manager is responsible for the education of all	4/13
Q 105	416.44(c) EMERGENCY EQUIPMENT Emergency equipment available to the operating rooms must include at least the following: (1) Emergency call system. (2) Oxygen. (3) Mechanical ventilatory assistance equipment including airways, manual breathing bag, and ventilator. (4) Cardiac defibrillator. (5) Cardiac monitoring equipment.	~~Q 105~~		

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Q 101	Continued From page 3 equipped so that the types of surgery conducted can be performed in a manner that protects the lives and assures the physical safety of all individuals in the area. This STANDARD is not met as evidenced by: Observation with the Administrator in procedure room #1 on April 3, 2012, at 2:30 p.m., revealed 20 culture swabs with an expiration date of July 2011. Interview with the Administrator in procedure room #1 on April 3, 2012, 2:30 p.m., confirmed the culture swabs were expired and available for patient use. Observation on April 3, 2012, during the facility tour, between 1:00 p.m. and 3:00 p.m., in the Endoscopy procedure room 7, revealed nine thin prep CytoLyt specimen bottles in the cabinet with an expiration date of October 2010. Interview with the Unit Manager and the facility administrator, in the procedure room, confirmed the specimen bottles were expired and available for use.	Q 101	procedure room assistants regarding the supply checklist and their responsibility for weekly monitoring and documentation. The procedure room assistants are responsible for monitoring supplies on a weekly basis and documenting completion of this task. The unit manager will monitor completion of this task on a monthly basis. This responsibility will be added to the monthly Environment of Care rounds. Any variances/trends will be reported to the QAPI committee.	
Q 105	416.44(c) EMERGENCY EQUIPMENT Emergency equipment available to the operating rooms must include at least the following: (1) Emergency call system. (2) Oxygen. (3) Mechanical ventilatory assistance equipment including airways, manual breathing bag, and ventilator. (4) Cardiac defibrillator. (5) Cardiac monitoring equipment.	Q 105	next pg	

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Q 105	Continued From page 4 (6) Tracheostomy set. (7) Laryngoscopes and endotracheal tubes. (8) Suction equipment. (9) Emergency medical equipment and supplies specified by the medical staff. This STANDARD is not met as evidenced by: Based on observation, interview and review of facility policy, the facility failed to ensure expired medical supplies were removed from the crash cart; failed to maintain daily check list for one of two crash carts within the facility; and failed to ensure the batteries were not expired for two of four laryngoscopes in one of the facility's two Emergency Carts. The findings included: Observation on April 3, 2012, at 2:00 p.m., during the facility tour, in the Endoscopy nurse's station, revealed expired Fast Patch Pads (defibrillator pads), dated 10/28/2011, in the top drawer of the crash cart. Interview on April 3, 2012, at 2:05 p.m., with the Unit Manager, in the nurse's station, confirmed the Fast Patch Pads were expired and were available for use. Review of the facility policy Emergency Code Cart, revealed "...the code cart will be appropriately stocked and checked monthly on a scheduled basis and all required checks will be documented on the Code Cart Checklist...". Observation on April 3, 2012, during the facility	Q 105	**Q 105 416.44(c) EMERGENCY EQUIPMENT** Plan of Correction Expired medical supplies will be removed from the crash cart. A daily check list for both of the crash carts will be maintained and documentation of daily checks will be completed. All expired laryngoscope batteries will be removed and replaced with batteries that are not expired. Systemic Changes A daily crash cart check list will be instituted for both crash carts that include all crash cart items that have an expiration date. The checklist will also document that all patient care supplies are protected in plastic bags and the cart is inspected for overall cleanliness. (See attached crash cart check list) An RN will be assigned to perform and document daily checks of both of the crash carts. A second RN will be assigned as a "back up" in the event of the first assigned RN's absence. Cont	4/13

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Q 105	Continued From page 5 tour, between 1:00 p.m. and 3 p.m., in the Endoscopy nurse's station, revealed the crash cart Daily Check List was not signed by a licensed nurse on the following dates: October 6, 2011, October 25, 2011, November 10, 11, 14 and 31, 2011, and December 12, 2011. Interview on April 3, 2012, at 1:40 p.m., with the unit manager, in the nurse's station, confirmed the crash cart checklist was not signed by a licensed nurse and the facility failed to follow policy. Review of the facility policy Emergency Equipment and Maintenance, revealed "...a licensed nurse will be assigned to check the emergency cart on a daily basis...documentation of testing of equipment will be maintained in a log kept on the emergency crash cart..." Observation with the Administrator on April 4, 2012, at 2:00 p.m., of one of two of the facility's Emergency Carts revealed two of four laryngoscope handles (utilized to provide light in the insertion of a tube in the throat of the patient to allow for an airway) with batteries with an expiration date of March 2005. Interview with the Administrator on April 4, 2012, at 2:00 p.m., confirmed the batteries had expired in the laryngoscope handles.	Q 105	Responsible Party and Monitoring The unit manager or designee will be responsible for making the appropriate changes to the crash cart checklist (as outlined above) and ensuring this checklist is present on both crash carts. The assigned RN (or the "back-up" RN) will be responsible for completing the checklist for both crash carts on a daily basis. This RN will be responsible for removing and replacing all expired items as needed. The unit manager will be responsible for monitoring the daily completion of the crash cart checklists on a monthly basis. This responsibility will be added to the monthly Environment of Care rounds. Any variances/trends will be reported to the QAPI committee.	
Q 181	416.48(a) ADMINISTRATION OF DRUGS Drugs must be prepared and administered according to established policies and acceptable standards of practice.	Q 181		

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Q 181	Continued From page 6 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure medications with a potential for abuse were monitored for count; failed to ensure unused medications with a potential for abuse were wasted per protocol; and failed to ensure to ensure expired medications were not available for patient use. The findings included: Observation in the medication storage room with the Administrator on April 3, 2012, at 2:10 p.m., revealed a four by six foot locked closet with three shelves on three walls containing numerous boxes of Propofol (Sedative/Anesthetic medication). Continued observation revealed the boxes contained 10 mg (milligram) vial, 20 mg vials, and 50 mg vial of Propofol. Continued observation revealed one medication reconciliation sheet (to be filled out every time a medication is removed and totaled to reflect the remaining number of vials of medication) for Propofol 10 mg vial. Continued observation revealed the sheet was incomplete and reflected the same remaining amount for numerous removals of medications and some removal of medications the lacked documentation of how many vials were removed. Interview in the medication storage room with the Administrator on April 3, 2012, at 2:10 p.m., confirmed the medication reconciliation sheet was not accurately filled out and there were no sign out sheets for the 20 mg or 50 mg vials.	Q 181	**Q 181 416.48(a) ADMINISTRATION OF DRUGS** Plan of Correction The Center will ensure that all medications with a potential for abuse will be monitored for count. The Center will ensure that all medications with a potential for abuse will be wasted per protocol. The Center will ensure that all pre-drawn syringes will be labeled with drug name, dosage, date and time drawn up, date and time of expiration, and initials of person preparing the syringe. The Center will ensure that all expired medications will not be available for patient use. The Center will ensure that all medications are appropriately secured at all times. Systemic Changes Center administrator or designee will conduct an inservice with all Center CRNA's on _____ regarding the	4/16

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Q 181	Continued From page 7 Observation in procedure room #5 on April 3, 2012, at 10:00 a.m., with CRNA (Certified Registered Nurse Anesthetist) #1, revealed the 3 quart sharps container had two 10 ml (milliliter) containing approximately 4 ml of a milky colored substance present in the syringes. Interview in procedure room #5 on April 3, 2012, at 10:00 a.m., with CRNA #1, confirmed the substance in the syringes was Propofol and the unused Propofol was to be disposed of by wasted or discarded it into the trash or sink to render it unavailable for further use. Observation in procedure room #5 on April 3, 2012, at 10:00 a.m., with the Infection Control Preventionist revealed the following pre-drawn, undated or expired syringes of medication in an unlocked drawer: three 10 ml syringes labeled as Sodium Chloride 0.9% without a date as to when the medication was drawn into the syringes; one 10 ml syringes labeled as Sodium Chloride 0.9% with a n expiration date listed as March 6, 2012; and one 10 ml syringes labeled as Sodium Chloride 0.9% with an expiration dated listed as March 13, 2012. Interview in procedure room #5 on April 3, 2012, at 10:00 a.m., with the Infection Control Preventionist confirmed the medications had expired and were available for patient use. Observation with the Administrator on April 3, 2012, at 2:10 p.m., of one of two of the facility's Emergency Carts revealed six 10 ml vial of Amidate (short acting intravenous anesthetic agent) 20 mg (milligrams) per ml with an expiration date of March 1, 2012. Continued	Q 181	appropriate procedure for storage, accounting and disposal of Propofol to include the following: 1) Storage & Accounting - Propofol count sheets have been revised to include all Propofol dosages and an accounting of all boxes removed and returned. This will be documented by two licensed staff members. (See attached Propofol count sheet) The administrator or designee, along with a second licensed Center staff member will reconcile the Propofol count on a weekly basis. Any discrepancies will be reported to the Administrator. Propofol will be stored under double lock and the administrator or designee will maintain control of the keys. 2) Disposal – All unused Propofol not in the original unopened container is to be discarded in the appropriate receptacle. All CRNA's and Center staff will receive training on safe injection practices through review of the CDC's "One and Only" campaign material by 05-01-2012. (See attached document)	

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Q 181	Continued From page 8 observation revealed the 8 gallon sharps container situated next to the Emergency Cart contained one, almost full 20 ml vial of Propofol 10 mg/ml. Interview with the Administrator on April 3, 2012, at 2:10 p.m., confirmed the medication had expired and was available for patient use; and the vial of Propofol had not been discarded by wasting the medication into the trash or sink the per nursing protocol. Observation in procedure room #8 with the Administrator on April 3, 2012, at 2:30 p.m., revealed and unsecure drawer in the room with two 1 ml (milliliter) vials of Epinephrine 1:10:000 (utilized to increase blood pressure and stimulate the heart muscle). Continued observation revealed one of the vials had expired April 1, 2012. Observation on April 3, 2012, during the facility tour, between 1:00 p.m. and 3:00 p.m., in the Endoscopy Room 6 Procedure room, revealed two Epinephrine (1:10,000) 1mg/1ml (10ml), in an unlocked drawer and unsecured. Continued observation of procedure room 7 revealed one Epinephrine (1:10,000) 1mg/1ml (10cc) in an unlocked drawer and unsecured. Interview with the nurse manager and the facility administrator, at 2:15 p.m., in the procedure room, confirmed the Epinephrine vials were in an unlocked and unsecured drawer in the procedure rooms and available for use.	Q 181	All pre-drawn syringes will be labeled with drug name, dosage, date and time drawn up, date and time of expiration, and initials of person preparing the syringe. All medication vials will be labeled with date opened, date of expiration, and the initials of the person labeling the syringe. All medications stored in the procedure room will be added to the procedure room supply/medication checklist to be checked for expiration date and appropriate secured storage. This list will be monitored weekly by the procedure room assistant and documented with date and signature. All expired medications will be disposed of per Center policy. The unit manager will verify the completion of the weekly cheeks on a monthly basis. Responsible Party and Monitoring Center administrator will be responsible for conducting the inservice of all Center CRNA's regarding the Center requirements relative to the appropriate procedure for storage, accounting and disposal of Propofol. The Lead CRNA or designee will be responsible for Cont	
Q 223	416.50(a)(1)(ii) NOTICE - PHYSICIAN OWNERSHIP The ASC must also disclose, where applicable,	~~Q 223~~		

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	44C0001014	A. BUILDING _____ B. WING _____	04/04/2012

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Q 223	Continued From page 9 physician financial interests or ownership in the ASC facility in accordance with the intent of Part 420 of this subchapter. Disclosure of information must be in writing and furnished to the patient in advance of the date of the procedure. This STANDARD is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure the disclosure form of physician ownership was completed for four (#6, #12, #16, #18), and failed to ensure the disclosure form was current for five (#7, #15, #17, #19, #20) of twenty patients reviewed. The findings included: Medical record review revealed patient #6 was admitted to the facility on January 3, 2012, to undergo colonoscopy. Continued medical record review revealed the form entitled Important Billing Information About Your Procedure was not present in the record. Medical record review revealed patient #12 was admitted to the facility on November 8, 2011, to undergo a colonoscopy. Continued medical record review revealed the form entitled Important Billing Information About Your Procedure was not present in the record. Medical record review revealed patient #16 was admitted to the facility on January 19, 2012, to undergo Endoscopic Ultrasound Upper. Continued medical record review revealed the form entitled Important Billing Information About Your Procedure was not present in the record.	~~Q 223~~	conducting daily environmental audits for a period of two months (beginning 4-23-2012) and random monthly audits ongoing to monitor the appropriate disposal of unused Propofol, appropriate labeling of all syringes and vials, and appropriate secured storage of all medications used by the anesthetists. CRNA non-compliance will be documented and reported by the Lead CRNA or designee and given to the QAPI committee. The QAPI committee report will be sent to the Governing Board. All Center CRNA's are responsible for complying with the Center procedure for the storage, accounting and disposal of Propofol. All Center CRNA's are responsible for labeling all pre-drawn syringes and medication vials appropriately, as well as secured storage of all medications and disposal of expired medications. All Center employees and CRNA's are responsible for reviewing the CDC "One and Only" campaign materials by 05-01-2012. The Administrator or designee is responsible for ensuring 100% compliance with review of this material by the Center employees and CRNA's by 05-01-2012. The unit manager or designee is responsible for adding procedure room medications to the procedure room supply/medication list. The unit manager	

Cont

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Q 223	Continued From page 9 physician financial interests or ownership in the ASC facility in accordance with the intent of Part 420 of this subchapter. Disclosure of information must be in writing and furnished to the patient in advance of the date of the procedure. This STANDARD is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure the disclosure form of physician ownership was completed for four (#6, #12, #16, #18), and failed to ensure the disclosure form was current for five (#7, #15, #17, #19, #20) of twenty patients reviewed. The findings included: Medical record review revealed patient #6 was admitted to the facility on January 3, 2012, to undergo colonoscopy. Continued medical record review revealed the form entitled Important Billing Information About Your Procedure was not present in the record. Medical record review revealed patient #12 was admitted to the facility on November 8, 2011, to undergo a colonoscopy. Continued medical record review revealed the form entitled Important Billing Information About Your Procedure was not present in the record. Medical record review revealed patient #16 was admitted to the facility on January 19, 2012, to undergo Endoscopic Ultrasound Upper. Continued medical record review revealed the form entitled Important Billing Information About Your Procedure was not present in the record.	~~Q 226~~ Q 181 cont Q 223	is responsible for the education of all procedure room assistants regarding the supply/medication checklist and their responsibility for weekly monitoring and documentation of expiration dates as well as secured storage of this medication. The unit manager will monitor completion of this task on a monthly basis. This responsibility will be added to the monthly Environment of Care rounds. Any variances/trends will be reported to the QAPI committee. **Q223 416.50(a)(1)(ii) NOTICE – PHYSICIAN OWNERSHIP** Plan of Correction The Center will ensure the documentation of receipt of information relative to the disclosure of physician ownership by every patient at every patient visit. Systemic Changes Physician ownership disclosure information will be given to and discussed with each patient at their initial Center visit. (See attached multiple authorization form). At each subsequent	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/05/2012
FORM APPROVED
OMB NO. 0938-0391

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Q 223	Continued From page 10 Medical record review revealed patient #18 was admitted to the facility on February 7, 2012, to undergo a Sigmoidoscopy and Endoscopic Ultrasound Upper. Continued medical record review revealed the for entitled Important Billing Information About Your Procedure was not present in the record. Review of the form Important Billing Information About Your Procedure contained the disclosure statement "...I have been informed by the staff that the physician who is rendering services has an ownership interest in...(named facility)...". Medical record review revealed patient #7 was admitted to the facility on January 11, 2012, to undergo colonoscopy. Continued medical record review revealed the disclosure form in the record was dated November 2, 2011, and was not updated for the current procedure. Medical record review revealed patient #15 was admitted to the facility on December 9, 2011, to undergo colonoscopy. Continued medical record review revealed the disclosure form in the record was dated October 4, 2011, and had not been updated for the current procedure. Medical record review revealed patient #17 was admitted to the facility on January 30, 2012, to undergo Esophagoduodenoscopy (visualization of upper gastrointestinal tract). Continued medical record review revealed the disclosure form in the record was dated December 11, 2011, and had not been updated for the current procedure. Medical record review revealed patient #19 was admitted to the facility on February 29, 2012, to	Q 223	visit, the information will be discussed with the patient, and the patient will be asked to sign and date the same multiple authorization form indicating their continued understanding and agreement with its contents. The patient will receive their own copy of the updated multiple authorization form at each visit. Confirming the presence of patient signature and date on the multiple authorization form will be added to the medical record audit. Center staff will be inserviced by the administrator or designee on 04-20-2012 regarding this process. Responsible Party and Monitoring The administrator or designee will be responsible for inservicing the staff regarding the process for obtaining confirmation of patient receipt and understanding of physician ownership disclosure information. The Center staff is responsible for ensuring that patients have reviewed the physician ownership disclosure at each Center visit. The staff member(s) responsible for medical chart audit will report any trends/variances to the QAPI committee. The QAPI committee report will be sent to the Governing Board.	4/11

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Q 223	Continued From page 11 undergo Esophagoduodenoscopy and Endoscopic Ultrasound Upper. Continued medical record review revealed the disclosure form in the record was dated January 11, 2012, and had not been updated for the current procedure. Medical record review revealed patient #20 was admitted to the facility on March 5, 2012, to undergo colonoscopy. Continued medical record review revealed the disclosure form in the record was dated December 19, 2011, and had not been updated for the current procedure. During interview on April 3, 2012, at 3:10 p.m., in the conference room, the assistant administrator confirmed the disclosure forms were not present in the records of patients #6, #12, #16, #18, and the disclosure form had not been updated for patients #7, #15, #17, #19, #20. In continued interview the assistant administrator confirmed a disclosure form should be signed by each patient; should be present in the record; and should be updated for each procedure.	Q 223		
Q 242	416.51(b) INFECTION CONTROL PROGRAM The ASC must maintain an ongoing program designed to prevent, control, and investigate infections and communicable diseases. In addition, the infection control and prevent program must include documentation that the ASC has considered, selected, and implemented nationally recognized infection control guidelines. This STANDARD is not met as evidenced by: Based on observation and interview, the facility	Q 242	**Q 242 416.51(b) INFECTION CONTROL PROGRAM** Plan of Correction The Center will ensure that all stretchers are maintained in good repair. The Center will maintain that all cabinets in procedure rooms are maintained in good repair. The Center will ensure that all patient care items have not expired.	

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Q 242	Continued From page 12 failed to ensure one of eight stretchers were maintained in good repair to allow cleaning; failed to ensure one cabinet in one of eight procedure rooms was maintained in good repair to allow cleaning; and failed to ensure patient care supplies had not expired in one of eight procedure rooms. The findings included: Observation in the post-operative area with Registered Nurse #1, on April 3, 2012, at 9:40 a.m., revealed a patient stretcher with thread bare, dime sized areas of the protective covering of the foam mattress pad at head and waist level. Interview with Registered Nurse #1, on April 3, 2012, at 9:40 a.m., confirmed the stretcher was in use and the breeches in the protective covering made it impossible to clean the mattress pad between patient use. Observation with Medical Assistant (MA) #1 in procedure room #5 on April 3, 2012, at 9:45 a.m., revealed a bedside supply cabinet to have rust covering the handle areas of all three drawers. Interview with the Infection Control Preventionist in procedure room #5 on April 3, 2012, at 10:20 a.m., confirmed the rusted areas were unable to be cleaned.	Q 242	Systemic Changes The stretcher pad identified as being in disrepair has been discarded. All Center stretcher pads have been evaluated by the manufacturer's representative. All pads that can be restored will be restored by the manufacturer. All pads deemed as unable to be restored will be discarded by 05-01-2012. All supply cabinets with visible rust have been removed from patient care areas. All cabinets are scheduled to be evaluated by the building contractor on 4-17-2012. Repair or replacement will be completed for all cabinets in question by 05-01-2012. All stretchers and stretcher pads as well as all Center furnishings will be evaluated by the Center Administrator or designee for being in good repair. Evaluation of patient care stretchers and Center furnishings will be added to the monthly Environment of Care rounds. Expiration dates will be monitored for all patient care items (See plan of correction for Q101 416.44(a)(1)) Cont	5|1 5|1

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Q 242	Continued From page 12 failed to ensure one of eight stretchers were maintained in good repair to allow cleaning; failed to ensure one cabinet in one of eight procedure rooms was maintained in good repair to allow cleaning; and failed to ensure patient care supplies had not expired in one of eight procedure rooms. The findings included: Observation in the post-operative area with Registered Nurse #1, on April 3, 2012, at 9:40 a.m., revealed a patient stretcher with thread bare, dime sized areas of the protective covering of the foam mattress pad at head and waist level. Interview with Registered Nurse #1, on April 3, 2012, at 9:40 a.m., confirmed the stretcher was in use and the breeches in the protective covering made it impossible to clean the mattress pad between patient use. Observation with Medical Assistant (MA) #1 in procedure room #5 on April 3, 2012, at 9:45 a.m., revealed a bedside supply cabinet to have rust covering the handle areas of all three drawers. Interview with the Infection Control Preventionist in procedure room #5 on April 3, 2012, at 10:20 a.m., confirmed the rusted areas were unable to be cleaned.	Q 242	Responsible Party and Monitoring The Administrator or designee will be responsible for evaluation of all Center patient stretchers and Center furnishings to ensure that they are in good repair. All items found to not be in good repair will be either restored or replaced by the manufacturer. The Unit manager or designee is responsible for adding evaluation of all patient stretchers and Center furnishings to the Environment of Care rounds completed on a monthly basis. Any item found to be in disrepair will be removed and restored or replaced. The monthly Environment of Care report will be given to the QAPI committee.	

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A 002	1200-8-10 No Deficiencies During the Licensure survey conducted on April 3 - 4, 2012, at The Endoscopy Center, no deficient practices were cited under Chapter 1200-8-10, Standards for Ambulatory Surgery Treatment Centers.	A 002		

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K 144	416.44(b)(1) LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99, 3.4.4.1, NFPA 110, 8.4.2 This STANDARD is not met as evidenced by: NFPA 110 (1999) 5-3 Lighting. 5-3.1 The Level 1 or Level 2 EPS equipment location shall be provided with battery-powered emergency lighting. The emergency lighting charging system and the normal service room lighting shall be supplied from the load side of the transfer switch. Based on observation and interview, the facility failed to provide Battery-Powered Emergency Lighting in the Auto Transfer Switch location. The findings include: Observation and interview with the Financial Administrator on April 4, 2012 at 10:10 a.m. confirmed the Auto Transfer Switch room was not provided with battery-powered emergency lighting. Based on observation and interview, the facility failed to assure the emergency generator was provided with a remote annunciator in an continuously occupied area. (2000 NFPA 99, -4.1.1.15). The findings include: Observation and interview with the Financial Administrator on April 4, 2012 at 11:15 a.m. confirmed the emergency generator was not provided with a remote annunciator These findings were verified by the Financial Administrator and acknowledged by the	K 144	**K 144 418.44(b)(1) LIFE SAFETY CODE STANDARD** Plan of Correction The Center will provide battery-powered emergency lighting in the auto transfer switch location. The Center will ensure that the emergency generator is provided with a remote annunciator in a continuously occupied area. Systemic Changes The Center Administrator will coordinate with an electrician to assess and provide a quote to install back up emergency lighting in the generator emergency transfer switch location. This will be completed no later than 05-18-2012. The Center Administrator will coordinate with an electrical engineer to assess all requirements associated with placement of a remote annunciator for the back-up generator in a continuously occupied area of the Endoscopy Center. The expected completion date is 05-18-2012.	5/19 5/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 144	Continued From page 1 Administrator during the exit conference on April 4, 2012.	K 144	Responsible Party and Monitoring The Center Administrator will ensure all work is scheduled and completed in the designated time. Once installed, the Center Administrator or designee will monitor or test the function of the annunciator panel at least one time per month. This responsibility will be added to the Center EOC checklist.	

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A 801	1200-8-10-.08 (1) Building Standards (1) An ASTC shall construct, arrange, and maintain the condition of the physical plant and the overall ASTC environment in such a manner that the safety and well-being of the patients are assured. This Rule is not met as evidenced by: NFPA 101 (Life Safety Code 2000 edfition) states: 8.2.3.2.3.1 Every opening in a fire barrier shall be protected to limit the spread of fire and restrict the movement of smoke from one side of the fire barrier to the other. The fire protection rating for opening protectives shall be as follows: (1) 2-hour fire barrier - 11/2-hour fire protection rating (2) 1-hour fire barrier - 1-hour fire protection rating where used for vertical openings or exit enclosures, or 3/4-hour fire protection rating where used for other than vertical openings or exit enclosures, unless a lesser fire protection rating is specified by Chapter 7 or Chapters 11 through 42 Based on observation and record review, the facility failed to the assure the building fire walls were constructed as specified on the architectural plans. The findings include: Observation and review of the architectural plans, with the Financial Administrator, on April 4, 2012 at 11:00 a.m. confirmed the occupancy separation walls were shown as a 2-hour fire rated wall on the architectural plans with 4 of 4 fire rated doors specified as having a 90 minutes fire rating. Observation with the Financial Administrator of occupancy separation wall doors on April 4, 2012 at 11:00 a.m. confirmed 2 of 4 of	A 801	**A 801 1200-8-10-08 (1) BUILDING STANDARDS** Plan of Correction All fire/smoke barriers and associated openings will meet NFPA 101 Life Safety Code 2000 Edition Systemic Changes The Center Administrator will coordinate assessment of the existing fire barriers by a licensed architect and contractor on 4/17/2012 to determine current fire rating status. If it is determined existing doors do not meet the same standard as the fire barrier, replacements will be obtained and installed no later than 05-18-2012. Responsible Party and Monitoring The Center Administrator will ensure all require corrections take place in the timeframes as defined.	5/19

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A 801	Continued From page 1 the doors near the waiting room were rated for 20 minutes This finding was verified by the Financial Administrator and acknowledged by the Administrator during the exit conference on April 4, 2012.	A 801		

ACCREDITATION ASSOCIATION
for AMBULATORY HEALTH CARE, INC.

October 15, 2012

Organization #:	**13979**
Organization:	**The Endoscopy Center, LLC**
Address:	**801 North Weisgarber Road, Suite 100**
City, State, Zip:	**Knoxville, TN 37909-2707**
Decision Recipient:	**Gayle Mahan, RN**
Survey Date:	**October 1-2, 2012** **Type of Survey:** **Re-accreditation**
Survey Chairperson:	**Archer Rose, FACHE**
Survey Team Members:	**Laurence Hausman, MD**
	Garry Feld, BA, MS, FACHE

Accreditation Term Begins: **October 11, 2012** **Accreditation Term Expires:** **October 10, 2015**

Accreditation Renewal Code: **efad980b13979**
Complimentary study participation code: **13979FREEIQI**
Satellites: **See page 2**

Granting accreditation reflects confidence, based on evidence from this recent survey that you meet, and will continue to demonstrate throughout the accreditation term, the attributes of an accreditable organization, as reflected in the standards found in the *Accreditation Handbook for Ambulatory Health Care*. The dedication and effort necessary for an organization to be accredited is substantial and the compliance with those standards implies a commitment to continual self-evaluation and continuous improvement. If your organization was required to submit a plan for improvement, receipt of this letter denotes acceptance of the plan for improvement.

We hope the survey has been beneficial to your organization in identifying its strengths and opportunities to improve. AAAHC trusts that you will continue to find the accreditation experience meaningful, not only from the benefit of having carefully reviewed your own operation, but also from the recognition brought by your participation in this survey process.

Members of your organization should take time to review your Survey Report, which may arrive separately:

- Any standard marked "PC" (Partially Compliant) or "NC" (Non-Compliant) must be corrected promptly. Subsequent surveys by the AAAHC will seek evidence that deficiencies from this survey were addressed without delay.
- The Summary Table provides an overview of compliance for each chapter applicable to the organization.
- Statements in the "Consultative Comments" sections of the report represent the educational component of the survey. Such comments may provide helpful guidance for improvement.
- As a guide to the ongoing process of self-evaluation, periodic review of the Survey Report and the current year's *Handbook* will ensure the organization's ongoing compliance with the standards throughout the term of accreditation.

AAAHC policies and procedures and standards are revised on an annual basis, such revisions become effective March 1 each year. Accredited organizations are required to maintain their operations in compliance with the current AAAHC standards and policies. Therefore, the organization is encouraged to visit the AAAHC website, www.aaahc.org, for information pertaining to any revisions to AAAHC policies and procedures and standards.

In order to ensure continuation of accreditation, your organization should submit an application for survey approximately five months prior to your accreditation expiration. According to our *Accreditation Handbook*,

> *Currently-accredited organizations must complete and submit the Application for Survey, supporting documentation, and application fee for their subsequent full accreditation survey (referred to as a re-accreditation survey). Please visit www.aaahc.org to complete the Application for Survey and for further information. After review of an organization's completed Application for Survey and supporting documentation, the AAAHC will contact the organization to establish survey dates. To prevent a lapse in accreditation, an organization should ensure that all documentation is submitted to the AAAHC at least five (5) months prior to its accreditation expiration date. In states*

Organization #: 13979 **Accreditation Expires:** **October 10, 2015**
Organization: **The Endoscopy Center, LLC**
October 15, 2012
Page 2

where accreditation is mandated by law, an organization should submit the completed Application for Survey and other required documentation a minimum of six (6) months prior to its accreditation expiration date.

For submission of an application for survey, your organization will need the "*accreditation renewal code*" located underneath the accreditation expiration date.

You will notice that you have a "*complimentary study participation code*" at the top of this letter. You may use this to register for one of the AAAHC Institute for Quality Improvement's studies. Please visit www.aaahc.org/institute for additional information or contact Michelle Chappell, at 847-324-7747 or mchappell@aaahc.org.

If you have any questions or comments about any portion of the accreditation process, please contact the AAAHC Accreditation Services department at (847) 853-6060.

Satellites:

The Endoscopy Center, LLC - North
629 Delozier Way
Powell, TN 37849

The Endoscopy Center, LLC - West
11440 Parkside Drive, Suite 100
Knoxville, TN 37934

SUPPLEMENTAL #1

DSG Development Support Group

SUPPLEMENTAL #1
August 25, 2015
1:12 pm

August 21, 2015

Jeff Grimm, HSD Examiner
Tennessee Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

RE: CON Application #1508-030s
Endoscopy Center of Knoxville

Dear Mr. Grimm:

This letter responds to your recent request for additional information on this application. The items below are numbered to correspond to your questions. They are provided in triplicate, with affidavit.

1. Section A, Applicant Profile, Item 6

The 15-year option to sublease 16,732 rentable square feet in a new 50,000 SF 3-story building to be constructed on a 4.5 acre site at the intersection of Middlebrook Pike and Dowell Springs Boulevard in Knoxville, TN is noted.

a. Please provide proof of ownership of the 4.5-acre site by the owner identified in the document in the form of a copy of a title or deed.

RTG Dowell Springs, LLC is listed in the lease option as an owner. It holds four deeds to tracts comprising this project's site. Those deeds are attached at the end of this letter. The other owner listed in the option is DDC Dowell Springs, LLC. Its role is explained in a letter attached to the deeds. Both RTG and DDC signed the lease option, as did the intended master tenant (GIA, the practice) and its subtenant (the ASTC applying for the CON), assuring the CON applicant of site control.

b. Exhibit A reflects that the applicant will sublease 16,732 SF on the entire 2nd floor of the building. This amount appears to be different from the 17,173 SF used to calculate the lease cost for the Project Costs Chart on page 47 of the application. Please clarify.

Please see Exhibit A, item 2 in the lease option, which states 17,173 "rentable SF". That is the figure used in calculating lease costs. The smaller figure is the usable SF that exist within the applicant's premises. Their difference is the inclusion of a common area (halls, elevator, parking, etc.) factor when grossing up usable SF into rentable SF.

4219 Hillsboro Road, Suite 203
Nashville, TN 37215

jwdsg@comcast.net

Tel 615.665.2022
Fax 615.665.2042

SUPPLEMENTAL #1
August 25, 2015
1:12 pm

c. The terms also indicate that Gastrointestinal Associates, PC, as master tenant, will lease the entire building from the owner for use as medical office space and an ambulatory surgery center. Please briefly describe the plans for use of floors 1 and 2 in the new building such as exclusive use for physicians of Gastrointestinal Associates, PC.

Plans for all three floors are as follows:

Floor 1: Gastrointestinal Associates, P.C. will utilize this floor. It will contain a comprehensive weight management center, infusion suites, clinical trials spaces, medical records, human resources, staff kitchen and break area, and storage, and possibly other functions.

Floor 2: The Endoscopy Center of Knoxville, the licensed ASTC applying for the CON to relocate to this location.

Floor 3: Gastrointestinal Associates, P.C. will operate its medical practice on this floor, except for support activities listed above for the first floor. This will include management and physician offices as well as clinical practice rooms.

2. Section A, Applicant Profile, Item 5
The applicant's management services agreement effective in 1992 with AmSurg is noted. Was there a change in the management of the ASTC prior to that time from its original licensure by TDH in July 1986? Please provide a brief discussion of AmSurg's historical relationship with the applicant ASTC. In your response, please also identify the sites AmSurg manages in Tennessee.

AmSurg entered the relationship in 1992, as the document showed. AmSurg had no management or ownership interest in this facility, and no relationship with GIA (the medical practice) prior to that time. GIA itself managed its own endoscopy center.

A list of AmSurg facilities in Tennessee is provided following this page.

SUPPLEMENTAL #1
August 25, 2015
1:12 pm

Tennessee				
2001-001	Knoxville GI	The Endoscopy Center	865-588-5121	Knoxville
2001-002	Knoxville West GI	The Endoscopy Center - West	865-588-5121	Knoxville
2003-001	St Thomas GI	St. Thomas Medical Group Endoscopy Center	615-250-4108	Nashville
2007-001	Maryville GI	Tennessee Endoscopy Center	865-983-0073	Maryville
2018-001	Knoxville Eye	Eye Surgery Center of East Tennessee	865-588-1037	Knoxville
2063-001	Chattanooga GI	Chattanooga Endoscopy Center	423-698-3999	Chattanooga
2093-001	Middle Tennessee Multispecialty	The Surgery Center of Middle Tennessee	931-388-3488	Columbia
2114-001	Columbia TN GI	Mid-South Endoscopy Center	931-381-7818	Columbia
2120-001	Kingsport Eye	The Regional Eye Surgery Center	423-247-2022	Kingsport
2168-001	Nashville-Rivergate TN Eye	LVC Outpatient Surgery Center	615-859-3121	Goodlettsville
2213-001	Knoxville North TN GI	The Endoscopy Center North	865-588-5121	Powell
2216-001	Hermitage TN GI	Associated Endoscopy	615-316-3066	Hermitage

SUPPLEMENTAL #1
August 25, 2015
1:12 pm

3. Section B, Project Description, Item 1

Please provide the following additional information for the highlights noted in the executive summary:

a. It appears that physicians on the applicant's medical staff may also hold privileges at 2 other ASTCs in Knox County owned by the applicant (pages 12/42). It appears that these ASTCs were both licensed in 2005 and are located within 14 miles of the applicant's facility. What consideration was given, if any, as to the advantages/disadvantages of merging the facility into any of the other existing AmSurg Centers in Knoxville?

The two other ASTC's, which have only two procedure rooms each, were not acquired. They sought and received CON approval several years ago specifically to achieve wider geographic distribution of this particular practice's endoscopy services within Knox County. The goal was to provide quicker accessibility and convenience for the practice's patients who resided all across this large urban county. Consolidation is the opposite of what the medical staff and AmSurg intend to do in this service area.

b. In terms of resources noted in the executive summary and other parts of the application, please add a brief description about the medical staff, including where they practice in the service area by noting location of their private practices, and the name/location of other ASTCs and hospitals in the services where they hold staff privileges.

The medical staff of the facility are listed on the following page, along with their primary practice addresses. If this project is approved, all of them will have their primary practice office in the same building as the ASTC, in Dowell Springs.

In Knox County, they perform endoscopic surgery at The Endoscopy Center, The Endoscopy Center West, The Endoscopy Center North, Physicians Regional Medical Center, Tennova North, Fort Sanders Regional Medical Center, Thompson Cancer Center, and Parkwest Medical Center. Six GIA physicians have privileges at Jefferson Memorial Hospital, in Jefferson City (Jefferson County). One performs cases at Methodist Medical Center, Oak Ridge (Anderson County) and its hospital-based endoscopic surgery center.

SUPPLEMENTAL #1
August 25, 2015
1:12 pm

The Endoscopy Center Medical Staff and Current Office Location	
Physician	**Current Primary Office Address**
Barry V. Maves	801 N. Weisgarber Road, Knoxville, TN 37909
Sarkis J. Chobanian	801 N. Weisgarber Road, Knoxville, TN 37909
Charles M. O'Connor	801 N. Weisgarber Road, Knoxville, TN 37909
Meade C. Edmunds	801 N. Weisgarber Road, Knoxville, TN 37909
John M. Haydek	801 N. Weisgarber Road, Knoxville, TN 37909
Maria B. Newman	801 N. Weisgarber Road, Knoxville, TN 37909
Raj I. Narayani	801 N. Weisgarber Road, Knoxville, TN 37909
Steven J. Bindrim	801 N. Weisgarber Road, Knoxville, TN 37909
Scott L. Wilhoite	801 N. Weisgarber Road, Knoxville, TN 37909
Johnny Altawil	801 N. Weisgarber Road, Knoxville, TN 37909
John M. Moore	801 N. Weisgarber Road, Knoxville, TN 37909
Jeffrey Gilbert	988 Oak Ridge Turnpike, Oak Ridge, TN 37830

SUPPLEMENTAL #1
August 25, 2015
1:12 pm

c. The applicant notes action by Medicare between 2010-2013 to cease all ASTC space sharing arrangements and describes the significant impact to the facility as a result of same. If possible, please provide source information such as reference to directives, rules, or similar notices that can help facilitate a better understanding of the changes implemented by Medicare.

42 CFR416.44(a)(2) requires that "The ASC must have a separate recovery room and waiting area." This separation requirement was not enforced for some years by State Licensure agencies who conducted facility surveys on behalf of Medicare, and certified facilities for compliance with Medicare regulations. For this facility, that changed with the CMS survey conducted by the Tennessee Department of Health on October 4, 2012, and a subsequent citation on October 11, 2012 for not having such separations. The concept of separating the ASC from the practice by operating the former from 7 am to noon, and the latter from 1 pm to 6 pm, was accepted under a waiver from Medicare and the Tennessee Department of Health.

d. It appears that there are or will soon be 3 physicians without ownership interests in the LLC that will perform endoscopies at the facility. With 12,852 cases projected for Year 1, the average cases per physician amounts to approximately 1,071 cases per MD. Since one of the non-owners (Dr. Gilbert) estimates performing approximately 2,500 cases in Year 1, what opportunities might arise for him to be offered an ownership interest in the applicant LLC?

As with all physicians who have joined the GIA practice in the past, Dr. Gilbert will be evaluated over a two-year period, for contributions to gastroenterology care, professionalism, and compatibility with others in the practice. After a positive evaluation he will be offered partnership in the practice and the opportunity to acquire an ownership interest in the applicant LLC.

4. Section B, Project Description, Item II.A.

The description is noted. However, the Square Footage Chart accompanying the response for this item was omitted from the attachments. Please provide the chart that supports the size of the facility & related construction costs identified in other parts of the application, such as the Project Costs Chart.

The Chart is attached following this page.

5. Section C, Need Item 1, Specific Criteria –ASTC

ASTC, Item 2

a. Hours of Operation - please include a description of how the proposed schedule in Year 1 compares to the facility's current schedule, given the restrictions related to meeting Medicare requirements for separation of space discussed in Section B of the application.

Current Operating Hours: 7 am to noon, Monday-Friday.
Hours at the New Site: 7 am to 5 pm, Monday-Friday.

b. Projected Surgical Hours – Please include a brief description of how the projected surgical hours in Year 1 compare to the existing facility's current status.

Available Annual Hours to Schedule (Subtracting an hour for lunch)

(1) At Current Location:
4 hours per day X 8 rooms = 32 schedulable hours per day
32 hours per day X 250 days = 8,000 available hours

(2) At Proposed Location:
8 hours per day X 6 rooms = 48 schedulable hours per day
48 hours per day X 250 days = 12,000 available hours

ASTC, Item 11.d.

Please provide an update on status of contract with the 4th MCO available in the service area. Does the MCO need more provider members for this type of facility?

The State TennCare office has not yet completed its review of rate sheets and the applicant does not know the reason for their delay. All other paperwork is approved and waiting. The MCO appears to want and need this facility as a contracted member.

SUPPLEMENTAL #1
August 25, 2015
1:12 pm

6. Section C, Need Item 5 and 6 (Applicant's Historical and Projected Utilization)

a. Review of the utilization data provided and comparison to the JAR revealed that the applicant sent a 6/30/15 written request to TDH to provide some correction to the 2014 JAR (correspondence included in the attachments). Please briefly explain the nature & scope of same and whether or not this may impact the utilization identified in the application.

During preparation of the CON application, the applicant discovered that AmSurg's internal records of cases at all three Knoxville Endoscopy Centers did not match those facilities' JAR reports for FYE's 2011-13. The data were re-checked and the JAR corrections in the Attachments were sent in to the TDOH. The application was prepared using the *corrected* case numbers--where fiscal year data was required. However, most of the tables in the application show calendar year case data (which the JAR's do not provide).

b. The historical & projected utilization related to utilization by members of the medical staff is noted. For the 12,852 projected cases in Year 1, the breakout appears to be as follows:
Existing 11 medical staff MD utilization = 9,752 cases
New physicians - Drs. Gilbert & Moore = 3,100 cases
Total year 1 = 12,852 total cases
Is this an accurate reflection of the projected utilization for Year 1 as addressed in these parts of the application?

Yes.

c. The comments on both pages 15 and 42 appear to indicate that Dr. Gilbert is bringing 2,200 current cases, including 600 cases from 2 Knox County ASTCs owned by the applicant, plus 300 new cases from normal growth between 2015 and 2017. However, the August 11, 2015 letter from Drs. Gilbert & Moore appears to indicate that the 600 cases from the 2 other Knox County ASTCs will be transferred by Dr. Moore. Please clarify.

In the third sentence of the third paragraph of each page, the original sentence read: "....CY 2017. *Dr. Matthew Moore will bring 900 cases*--600 cases being currently performed...." Through an editing error the reference to Dr. Moore was deleted on both pages 15 and 42 (the latter having been copied from the prior). Attached after this page are revised pages 15R and 42R, with the deleted words re-inserted so that the sentence makes sense and states the physicians' cases clearly.

SUPPLEMENTAL #1
August 25, 2015
1:12 pm

d. The 2,500 projected cases by Dr. Gilbert amount to approximately 9.6 cases per day, based on 5 days per week/52 weeks per year. Please briefly describe how that level is realistic. In your response, please provide a breakout of the projected volumes by each physician of the medical staff for Year 1.

The applicant is not authorized to disclose individual physicians' case volumes because that is sensitive and proprietary practice information of each physician. Dr. Gilbert's and Dr. Moore's cases were disclosed with their permission, because they are new case commitments that must be quantified and documented to support the utilization projections and financial feasibility of the project.

Dr. Gilbert does in fact perform 2,200 cases per year. This is not unusual for an established gastroenterologist. Many physicians in this facility also perform cases at its two sister facilities (North and West). They average more than 2,100 cases per year at the three locations combined. And they perform additional inpatient cases at area hospitals.

Physician case times vary greatly. At this facility, on average, they take up to 35 minutes per case. At that rate, ten of them can be performed in less than six hours in one room. This staff will have six rooms at its disposal. A time analysis for the projected case volumes was provided on page 25 of the application, validating that there is sufficient time for these cases to be performed.

7. Section C, Economic Feasibility, Item 2 (Funding)

The August 10, 2015 letter from the CFO of AmSurg is noted. However, the loan schedule was omitted from the attachment. Please provide the schedule that supports the lease cost in the Project Cost Chart and the Projected Data Chart.

An amortization schedule is attached following this page. Also attached is a revised page 53R, the Projected Data Chart, with minor adjustments in the Line F Capital Expenditure data to correspond exactly with the amortization schedule.

Combined Notes

SUPPLEMENTAL #1
August 25, 2015
1:12 pm

2001-001 Knoxville GI

TOTAL FINANCED	6,681,000
Number of years	10
Annual Interest Rate	5.0%
Annual Payment	865,220

		Principal
Inception		$ 6,681,000
End Of Yr.	1	$ 6,149,830
End Of Yr.	2	$ 5,592,101
End Of Yr.	3	$ 5,006,486
End Of Yr.	4	$ 4,391,591
End Of Yr.	5	$ 3,745,950
End Of Yr.	6	$ 3,068,028
End Of Yr.	7	$ 2,356,209
End Of Yr.	8	$ 1,608,799
End Of Yr.	9	$ 824,019
End Of Yr.	10	$ 0
End Of Yr.	11	$ 0

LEVEL TOTAL PAYMENTS

	Principal Pmt.		Interest		Total Payment
$	531,170	$	334,050	$	865,220
$	557,729	$	307,491	$	865,220
$	585,615	$	279,605	$	865,220
$	614,896	$	250,324	$	865,220
$	645,641	$	219,580	$	865,220
$	677,923	$	187,298	$	865,220
$	711,819	$	153,401	$	865,220
$	747,410	$	117,810	$	865,220
$	784,780	$	80,440	$	865,220
$	824,019	$	41,201	$	865,220
$	-	$	-	$	-
$	6,681,000	$	1,971,201	$	8,652,201

SUPPLEMENTAL #1
August 25, 2015
1:12 pm

8. Section C. Economic Feasibility Item 4, Historical and Projected Data Charts The charts are noted. Please address the items below:

a. Historical Data Chart – the entries for taxes (Line D.4) and capital expenditures (Lines F.1 and F.2) appear to differ from the amounts shown in the applicant's Statement of Earnings for the period ending 12/31/15. As a result, Net operating income in the Chart appears to be understated. Please explain.

To follow the AmSurg calculations, please utilize the Historic Data Chart and also the ASTC's 2014 Statement of Earnings and 2014 Balance Sheet. The latter two are attached after this page, marked up for convenient reference.

Taxes

In CY 2014, the Historic Data Chart shows taxes of $174,364 in line D4. The facility's CY 2014 Statement of Earnings contains two entries for taxes, which total $174,364. The tax entries are circled on the Statement.

Capital Expenditures

In CY 2014, the Historic Data Chart shows a total of $151,872 capital expenditures--consisting of principal retirement ($149,556) and interest ($2,316).

The facility's CY 2014 Balance Sheet shows a CY2013 principal of $149,556 being paid off entirely in CY2014. So the Historic Data Chart correctly recorded principal retirement consistent with the Balance Sheet.

The facility's CY 2014 Statement of Earnings shows an interest amount of $1,867. The Historic Data Chart line D7 shows an interest amount of $449. Their total is $2,316. It is shown in line F2 of the Historic Data Chart.

SUPPLEMENTAL #1

August 25, 2015
1:12 pm

E02 IS Centers
Data as of MAY 26, 2015 at 8:36 a.m.

2001-001 Knoxville GI

Statement of Earnings
For the Period Ending December 31, 2014

	Monthly Actual	Monthly Budget	Prior Month	YTD Actual	YTD Budget	YTD Prior Year
Gross charges:						
GI revenue	1,800,484	1,454,002	1,397,248	17,454,957	17,136,013	20,400,296
Total gross charges	1,800,484	1,454,002	1,397,248	17,454,957	17,136,013	20,400,296
Estimated reserves:						
Contractual adjustments	1,243,137	1,002,480	983,485	12,064,650	11,809,853	14,100,654
Bad debt expense	12,603	11,632	9,781	217,185	137,089	192,802
Total estimated adjustments	1,255,740	1,014,112	993,266	12,281,835	11,946,942	14,293,456
Net revenue	544,744	439,890	403,983	5,173,122	5,189,071	6,106,840
Operating expenses:						
Salaries and benefits	221,587	241,351	175,401	2,407,309	2,896,212	2,878,240
Medical supplies and drugs	49,156	41,359	37,318	480,012	487,432	581,418
Other variable expenses	61,306	65,850	52,545	731,500	853,200	836,271
Fixed expenses	22,248	22,928	20,052	250,278	274,623	261,947
Operating taxes	2,023	3,220	1,430	taxes 36,022	38,640	39,701
Depreciation	19,891	18,671	19,172	231,163	227,312	238,173
Total operating expenses	376,211	393,379	305,919	4,136,283	4,777,419	4,835,750
Operating income	168,533	46,511	98,064	1,036,839	411,652	1,271,091
Other income and (expense):						
Interest expense, net	68	7	0	int. (1,867)	(2,230)	(8,082)
Fees and other	323	279	94	4,378	3,348	5,304
Earnings before income taxes	168,924	46,797	98,159	1,039,349	412,770	1,268,312
Income tax expense	18,214	11,875	14,420	taxes 138,342	97,859	146,418
Net earnings	150,710	34,922	83,738	901,007	314,911	1,121,894

TOT. TAXES #174,364 { 138,342 +36,022

SUPPLEMENTAL #1

August 25, 2015
1:12 pm

180

E01 Balance Sheet Centers
Data as of MAY 26, 2015 at 8:36 a.m.

2001 Knoxville GI

Balance Sheets
December 31, 2014

	Dec 2014	Nov 2014	Increase (Decrease)	Dec 2013	Increase (Decrease)
ASSETS					
Current assets:					
Cash and cash equivalents	533,662	485,924	47,739	310,859	222,804
Accounts receivable:					
Accounts receivable gross	2,298,483	1,981,154	317,329	2,031,102	267,381
Contractual allowance	(1,386,043)	(1,138,568)	(247,475)	(1,063,546)	(322,497)
Bad debt allowance	(92,751)	(66,844)	(25,907)	(143,767)	51,016
Accounts receivable, net	819,689	775,741	43,948	823,789	(4,100)
Other receivables	39,039	22,947	16,091	22,963	16,075
Supplies inventory	100,604	109,632	(9,028)	109,632	(9,028)
Prepaid and other current assets	43,482	40,586	2,896	40,946	2,536
Total current assets	1,536,475	1,434,830	101,645	1,308,188	228,287
Property and equipment:					
Building improvements	1,244,784	1,244,784	0	1,244,784	0
Equipment	3,585,246	3,563,580	21,666	3,512,734	72,512
	4,830,030	4,808,364	21,666	4,757,518	72,512
Accumulated depreciation	(3,968,186)	(3,945,312)	(22,873)	(3,695,632)	(272,553)
Property and equipment, net	861,844	863,051	(1,207)	1,061,885	(200,041)
Intangible assets:					
Goodwill, net	4,199,118	4,199,118	0	4,199,118	0
Other intangibles	52,078	45,249	6,829	59,862	(7,783)
Intangible assets, net	4,251,196	4,244,367	6,829	4,258,979	(7,783)
Total assets	6,649,515	6,542,248	107,267	6,629,052	20,463
LIABILITIES AND EQUITY					
Current liabilities:					
Accounts payable	284,134	285,870	(1,736)	236,263	47,871
Current income taxes payable	9,901	27,185	(17,285)	2,749	7,152
Accrued salaries and benefits	204,526	165,914	38,612	226,494	(21,968)
Other accrued liabilities	0	1,624	(1,624)	0	0
Intercompany payable (receivable)	4,279	7,391	(3,112)	5,398	(1,119)
	502,839	487,985	14,854	470,904	31,936
Long-term debt	0	0	0	149,556	(149,556)
Other long-term liabilities	165,526	165,614	(88)	182,942	(17,416)
Equity:					
GP capital account	3,050,387	3,003,212	47,175	2,981,282	69,105
LP capital account	2,930,763	2,885,438	45,325	2,864,369	66,395
Total equity	5,981,150	5,888,650	92,501	5,845,651	135,500
Total liabilities and equity	6,649,515	6,542,248	107,267	6,629,052	20,463

2013 PLAN PAID OFF IN 2014

SUPPLEMENTAL #1
August 25, 2015
1:12 pm

b. Review of the "Other Expenses" detail shows increases in contract services and maintenance of scopes. With 2 less procedure rooms at the new location what accounts for these?

Most of the endoscopes at the current location will be brought over to the new location. They are already old, and they will require increasing service and maintenance, in AmSurg's experience.

9. Section C, Economic Feasibility, Item 6.B.
The comparison of charges to other facilities is noted. The applicant's utilization is shown as 8,402 cases in FYE 2014. However, the utilization for FY2014 appears to be shown as 9,953 cases on page 39 and in the provider JAR. Please explain. If in error, please revise the table and submit a replacement page 55-R with your response.

Thank you for noticing that. The 8,402 cases are unduplicated patients, some of whom came back during the year for additional procedures. The 9,953 cases are the actual cases performed, as shown in the amended JAR and on page 39 of the application.

Attached after this page is a revised page 55R correcting the table. This makes the average charge data more consistent with the 2017 data shown immediately thereafter.

10. Section C, Orderly Development, Item 2
The analysis of impact is noted. This response and the attached letter from the 2 physicians states that Dr. Moore will transfer 600 cases from the other 2 AmSurg facilities in Knoxville. However, please note that the narrative on pages 15 and 42 indicates these cases may be transferred by Dr. Gilbert. Please clarify.

As stated in prior response 6(c), Dr. Moore will transfer the 600 cases. Pages 15 and 42 mistakenly deleted part of the sentence that had originally stated that Dr. Moore was the one moving the 600 cases.

C(II).6.B. COMPARE THE PROPOSED CHARGES TO THOSE OF SIMILAR FACILITIES IN THE SERVICE AREA/ADJOINING SERVICE AREAS, OR TO PROPOSED CHARGES OF PROJECTS RECENTLY APPROVED BY THE HSDA. IF APPLICABLE, COMPARE THE PROJECTED CHARGES OF THE PROJECT TO THE CURRENT MEDICARE ALLOWABLE FEE SCHEDULE BY COMMON PROCEDURE TERMINOLOGY (CPT) CODE(S).

Table Ten below compares the applicant's FYE 2014 and CY 2017 charges to the FYE 2014 charges of Nashville, Knoxville, and Maryville endoscopy centers.

Table Ten: Applicant's Charges in CY2017 Compared to FYE 2014 Charges at Dedicated Endoscopy Centers in Knoxville and Nashville

Facility	Cases (Patients)	Gross Charges	Gross Charges Per Case	Net Revenue	Net Revenue Per case
Digest. Disease Endo. Center (Nashville)	6,162	$9,148,179	$1,485	$5,242,063	$851
Nashville Endo. Center (Nashville)	2,870	$11,209,263	$3,906	$2,128,551	$742
The Applicant FYE 2014	**9,953**	**$17,668,336**	**$1,775**	**$5,367,724**	**$539**
The Applicant CY 2017	**12,852**	**$23,474,349**	**$1,827**	**$6,939,659**	**$540**
The Endoscopy Center West (Knox)	4,193	$8,937,499	$2,132	$2,501,911	$597
Associated Endoscopy (Nashville)	5,031	$8,220,082	$1,634	$2,902,350	$577
The Endoscopy Center North (Knoxville)	5,353	$11,650,650	$2,176	$3,018,963	$564
NV GI Endo. Center (Nashville)	2,594	$2,748,480	$1,060	$1,210,816	$467
Mid-State Endo. Center (Nashville)	2,436	$2,697,619	$1,107	$1,108,610	$455
Southern Endo. Center (Nashville)	2,711	$2,707,995	$999	$1,153,111	$425
Tennessee Endoscopy Center (Maryville)	7,081	$9,505,355	$1,342	$2,553,941	$361

Source: 2014 Joint Annual Reports of ASTC's and Projected Data Chart, this project.

The following page contains Table Eleven, showing the applicant's most frequent procedures performed, with their current Medicare reimbursement, and their projected Year One and Two average gross charges.

11. Affidavit

The affidavit appears to have been omitted from the application delivered to HSDA office on 8/14/15. Please provide same.

This is attached at the end of this letter along with the affidavit for this supplemental response.

Thank you for your assistance. We hope this provides the information needed to accept the application into the next review cycle. If more is needed please email or telephone me so that we can respond in time to be deemed complete.

Respectfully,

John Wellborn

John Wellborn
Consultant

SUPPLEMENTAL #1
August 25, 2015
1:12 pm

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF DAVIDSON

NAME OF FACILITY:

The Endoscopy Center (Knoxville)

I, JOHN WELLBORN, after first being duly sworn, state under oath that I am the lawful agent of the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete to the best of my knowledge.

Signature/Title
CONSULTANT

Sworn to and subscribed before me, a Notary Public, this the 25th day of August, 2015, witness my hand at office in the County of DAVIDSON, State of Tennessee.

NOTARY PUBLIC

My commission expires July 2 2018.

HF-0043

Revised 7/02

JAN M. DANFORTH
STATE OF TENNESSEE NOTARY PUBLIC
DAVIDSON COUNTY
My Commission Expires July 2, 2018

Additional Information Supplemental #1 -COPY-

Endoscopy Center of Knoxville

CN1508-030

DSG Development Support Group

SUPPLEMENTAL #1
August 28, 2015
4:16 pm

August 28, 2015

Jeff Grimm, HSD Examiner
Tennessee Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

RE: CON Application #1508-030s
Endoscopy Center of Knoxville

Dear Mr. Grimm:

This letter forwards a clarification of the first supplemental responses dated August 21. You requested further information documenting the Medicare or TDH Licensure acceptance of The Endoscopy Center's compliance with regulations in taking a time share approach to use of its space.

The reference to that is found in the Plan of Correction approved by the TDH, which is in the Attachments to the submitted application. To supplement that, attached is the TDH approval letter for that Plan of Correction. It appears that no Medicare waiver needed to be requested or granted, because TDH was performing inspections on Medicare's behalf.

Thank you for your assistance. We hope this provides the information needed to accept the application into the next review cycle. If more is needed please email or telephone me so that we can respond in time to be deemed complete.

Respectfully,

John Wellborn

John Wellborn
Consultant

4219 Hillsboro Road, Suite 203
Nashville, TN 37215

jwdsg@comcast.net

Tel 615.665.2022
Fax 615.665.2042

SUPPLEMENTAL #1
August 28, 2015
4:16 pm

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
OFFICE OF HEALTH LICENSURE AND REGULATION
EAST TENNESSEE REGION
5904 LYONS VIEW PIKE, BLDG. 1
KNOXVILLE, TENNESSEE 37919

July 09, 2012

Ms. Gale Mahan, RN, Administrator
The Endoscopy Center
801 Weisgarber Rd
Knoxville TN 37950

RE: 44C0001014

Dear Ms. Mahan:

The East Tennessee Region of Health Care Facilities conducted your annual recertification survey on April 3-4, 2012. An on-site revisit was conducted on May 3 and June 21, 2012. Based on the on-site revisit on May 3 and June 21, 2012 and review of your plan of correction, we are accepting your plan of correction and your facility is in compliance with all participation requirements as of May 19, 2012

If you have any questions, please contact the East Tennessee Regional Office by phone: 865-588-5656 or by fax: 865-594-5739.

Sincerely.

Karen B Kirby | KK

Karen B. Kirby, RN
Regional Administrator
East TN Health Care Facilities

KK: kg

TN000

SUPPLEMENTAL #1
August 31, 2015
12:19 pm

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF DAVIDSON

NAME OF FACILITY:

The Endoscopy Center (Knoxville)

I, JOHN WELLBORN, after first being duly sworn, state under oath that I am the lawful agent of the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete to the best of my knowledge.

John L Wellborn

Signature/Title
CONSULTANT

Sworn to and subscribed before me, a Notary Public, this the 31st day of August, 2015, witness my hand at office in the County of DAVIDSON, State of Tennessee.

Jan M. Danforth

NOTARY PUBLIC

My commission expires July 2, 2018.

HF-0043

Revised 7/02

JAN M. DANFORTH
STATE OF TENNESSEE NOTARY PUBLIC
DAVIDSON COUNTY
My Commission Expires July 2, 2018

LETTER OF INTENT -- HEALTH SERVICES & DEVELOPMENT AGENCY

The Publication of Intent is to be published in the Knoxville News Sentinel, which is a newspaper of general circulation in Knox County, Tennessee, on or before August 9, 2015, for one day.

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. Sections 68-11-1601 et seq., and the Rules of the Health Services and Development Agency, that The Endoscopy Center (an ambulatory surgical treatment center), owned by The Endoscopy Center of Knoxville, L.P. (a limited partnership), and managed by AmSurg Corp (a corporation), intends to file an application for a Certificate of Need to relocate from 801 Weisgarber Road, Suite 100, Knoxville, TN 37950 to an unaddressed site in the northwest quadrant of the intersection of Middlebrook Pike (TN 169) and Dowell Springs Boulevard in Knoxville, a distance of approximately 1.4 miles, and to reduce its procedure room complement from eight (8) to six (6) rooms. The project cost for CON purposes is estimated at $14,000,000, of which approximately $6,500,000 will be the actual capital cost. The balance consists of long-term lease payments that must be included under CON rules.

This facility is currently licensed by the Board for Licensing Health Care Facilities as a single specialty ambulatory surgical treatment center limited to endoscopy. The relocation will not change the facility's license classification. The project does not contain major medical equipment or initiate or discontinue any other health service; and it will not affect any facility's licensed bed complements.

The anticipated date of filing the application is on or before August 14, 2015. The contact person for the project is John Wellborn, who may be reached at Development Support Group, 4219 Hillsboro Road, Suite 210, Nashville, TN 37215; (615) 665-2022.

John L. Wellborn 8-10-15 jwdsg@comcast.net

(Signature) (Date) (E-mail Address)

CERTIFICATE OF NEED
REVIEWED BY THE DEPARTMENT OF HEALTH
DIVISION OF POLICY, PLANNING AND ASSESSMENT
615-741-1954

DATE: September 30, 2015

APPLICANT: The Endoscopy Center of Knoxville
801 Weisgarber Road
Knoxville, Tennessee

CN1508-030

CONTACT PERSON: John Wellborn
4219 Hillsboro Rd., Suite 210
Nashville, Tennessee 37215

COST: $13,791,800

In accordance with Section 68-11-1608(a) of the Tennessee Health Services and Planning Act of 2002, the Tennessee Department of Health, Division of Policy, Planning, and Assessment, reviewed this certificate of need application for financial impact, TennCare participation, compliance with *Tennessee's State Health Plan*, and verified certain data. Additional clarification or comment relative to the application is provided, as applicable, under the heading "Note to Agency Members."

SUMMARY:

The Endoscopy Center of Knoxville, L.P. seeks Certificate of Need (CON) approval to relocate from 801 Weisgarber Road, Suite 100, Knoxville, Tennessee, 37950, to an unaddressed site in the northwest quadrant of the intersection of Middlebrook Pike and Dowell Springs Boulevard in Knoxville, a distance of 1.4 miles, and reduce its procedure room complement from eight to six rooms.

The facility is currently licensed as an ambulatory surgical treatment center (ASTC) limited to endoscopy. The relocation will not change the facility's license classification. The project does not contain major medical equipment or initiate or discontinue any other health service; and does not affect the facility's licensed bed compliment.

The applicant will lease 16,555 square feet at a renovated cost of $204.32 per square foot.

The facility is owned by The Endoscopy Center of Knoxville, L.P. This limited partnership's general partner is AmSurg, KED, Inc., a wholly owned subsidiary of AmSurg Corp. The L.P.'s limited partner is "The Endoscopy Center", (a Tennessee general partnership composed of nine gastroenterologists in the medical practice named Gastrointestinal Associates). AmSurg Corp has a management contract with the ASTC.

The total estimated project cost is $13,791,719 and will be funded by AmSurg Corp in a loan to the applicant of the full actual capital expense of the project. The availability of funding is doc8mented in Attachment C, Economic Feasibility-2.

This application has been placed on the Consent Calendar. Tenn. Code Ann. § 68-11-1608 Section (d) states the executive director of Health Services and Development Agency may establish a date of less than sixty (60) days for reports on applications that are to be considered for a consent or emergency calendar established in accordance with agency rule. Any such rule shall provide that, in order to qualify for the consent calendar, an application must not be opposed by any person with legal standing to oppose and the application must appear to meet the established criteria for the issuance of a certificate of need. If opposition is stated in writing prior to the application being

formally considered by the agency, it shall be taken off the consent calendar and placed on the next regular agenda, unless waived by the parties.

GENERAL CRITERIA FOR CERTIFICATE OF NEED

The applicant responded to all of the general criteria for Certificate of Need as set forth in the document *Tennessee's State Health Plan.*

NEED:
The applicant's service area is Anderson, Blount, Jefferson, Hamblen, Knox, and Sevier counties.

County	2015 Population	2019 Population	% of Increase/ (Decrease)
Anderson	77,285	78,731	1.9%
Blount	131,578	138,116	5.0%
Jefferson	55,028	57,733	4.9%
Hamblen	64,894	66,616	2.7%
Knox	460,612	483,425	5.0%
Sevier	99,290	106,657	7.4%
Total	**888,687**	**931,278**	**4.8%**

Tennessee Population Projections 2000-2020, 2015 Revised UTCBER, Tennessee Department of Health

The ASTC opened in 1986 and shared some support spaces with Gastrointestinal Associates (GIA), its medical staff's group practice office. Several years ago, Medicare compelled ASTCs to stop sharing space with adjoining medical practices. The facility had no adjoining space in which to expand to create such separation. As a result, the medical practice obtained State and Medicare approval for the ASTC to use the facility from 7AM to 12 noon, while the practice would use the space from 12 noon to 5PM. This reduced the surgical schedule by 50% in 2013. This limitation and the subsequent death of the Center's busiest surgeon, and the obsolete design of the small, 29 year old facility reduced utilization from 11,251 cases in CY 2013, to 9,560 in CY2015. Additionally, the time has come to modernize The Endoscopy Center's physical space to meet AIA guidelines. The current physical space is three decades old.

According to the applicant, there are seven ASTCs performing endoscopies in the service area. The utilization of these rooms in 2014 was 1,865 cases per rooms, of 89% of the State Health optimal standard for procedure rooms.

Service Area ASTCs 2014

Facility	# ORs Rooms	# Procedure Rooms	FY Cases	FY Cases per OR	FY Cases	FY Cases per Room
Children's West Surgery Center	3	0	4,569	1,523	0	0
Ft. Sanders West Surgery Center	4	0	2,003	501	0	0
Parkwest Surgery Center	5	1	3,704	741	1,639	1,639
The Endoscopy Center	0	8	0	0	9,953	1,244
The Endoscopy Center North	0	2	0	0	6,237	3,119
The Endoscopy Center West	0	2	0	0	4,929	2,465
Tennessee Endoscopy Center	0	3	0	0	7,081	2,360
Total	**12**	**16**	**10,276**	**856**	**29,839**	**1,865**

Source: *Joint Annual Report of Ambulatory Surgical Treatment Centers 2014 Final,* Tennessee Department of Health, Division of Policy, Planning, and Assessment-Office of Health Statistics.

In 2017, with a full-day schedule, The Endoscopy Center projects 12,852 cases. In 2018, they are projecting 12,981 cases.

TENNCARE/MEDICARE ACCESS:
The Endoscopy Center participates in the Medicare and TennCare programs and will continue to do so. The applicant contracts with United Healthcare Community Plan, BlueCare, and TennCare Select. The applicant has requested a contract with AmeriGroup.

The applicant payor mix for 2014-15 was $14,084,609 in total revenues or 60% of total gross revenues and TennCare revenues of $2,437,434 or 1% of total gross revenues.

ECONOMIC FACTORS/FINANCIAL FEASIBILITY:
The Department of Health, Division of Policy, Planning, and Assessment have reviewed the Project Costs Chart, the Historical Data Chart, and the Projected Data Chart to determine if they are mathematically accurate and if the projections are based on the applicant's anticipated level of utilization. The location of these charts may be found in the following specific locations in the Certificate of Need Application or the Supplemental material:

Project Costs Chart: The Project Costs Chart is located on page 47 of the application. The total project cost is $13,791,719; of which $6,910,800 is fair market value (FMV) of the 15-year lease payments.

Historical Data Chart: The Historical Data Chart is located on page 52 of the application. The Historical Data Chart is located on page 51 of the application. The applicant reported 11,462, 11,251, and 9,652 cases in 2012, 2013, and 2014, with gross net operating revenues of $954,586, $927,774, and 751,451 each year, respectively.

Projected Data Chart: The Projected Data Chart is located on page 53R in Supplemental 1. The applicant project 12,852 and 12,981 cases in years one and two with net operating revenues of $87,875 and $50,179, each year respectively**.**

The applicant projected charges, deductions and net charge are provided below:

	FY2017	FY2018
Cases	12,852	12,981
Average Gross Charge Per Case	$1,827	$1,845
Average Deduction per Case	$1,287	1,305$
Average Net Revenue Per Case	$540	540$
Average Net Operating Income Per Case Before Capital Expenses	$74	$71

The applicant compares charges with other service type providers on page 54.

Several years ago, Medicare compelled ASTCs to stop sharing space with adjoining medical practices. The facility had no adjoining space in which to expand to create such separation. At the proposed site, a third party will provide the newly constructed shell building; but the applicant's construction will all be build-out.

CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTHCARE:
The applicant has a transfer agreement in place with Tennova Health System directly across from the proposed new location.

The current location is undersized and does not allow for full use of the surgery center. The proposed new location will be enlarged and redesigned to be highly efficient and patient-friendly.

AmSurg and GIA physicians own a network of three ASTCs in Knox County. One physician will transfer 600 cases from the North Knoxville facility without significant impact. Another will transfer approximately 2,200 cases; 440 cases from Covenant Health System's Methodist Medical Center, and 1,760 cases Tennessee Endoscopy Center.

The applicant provides the current and projected staffing for this on page 63 of the application.

The applicant is licensed by the Tennessee Department of Health and accredited by the Accreditation Association for Ambulatory Healthcare (AAAHC).

SPECIFIC CRITERIA FOR CERTIFICATE OF NEED

The applicant responded to all relevant specific criteria for Certificate of Need as set forth in the document *Tennessee's State Health Plan.*

SPECIFIC CRITERIA FOR CERTIFICATE OF NEED

The applicant responded to all relevant specific criteria for Certificate of Need as set forth in the document *Tennessee's State Health Plan.*

AMBULATORY SURGICAL TREATMENT CENTERS

Assumptions in Determination of Need
The need for an ambulatory surgical treatment center shall be based upon the following assumptions:

Operating Rooms

a. An operating room is available 250 days per year, 8 hours per day.

b. The estimated average time per Case in an Operating Room is 65 minutes.

c. The average time for cleanup and preparation between Operating Room Cases is 30 minutes.

d. The optimum utilization of a dedicated, outpatient, general-purpose Operating Room is 70% of full capacity. 70% x 250 days/year x 8 hours/day divided by 95 minutes = 884 Cases per year.

This facility will not have operating rooms; only procedure rooms.

Procedure Rooms

a. A procedure room is available 250 days per year, 8 hours per day.

The facility will be operated from 7am to 4pm, Monday thru Friday, 50 weeks per year.

b. The estimated average time per outpatient Case in a procedure room is 30 minutes.

The applicant complies. The average time per case will be 25 minutes.

c. The average time for cleanup and preparation between Procedure Room Cases is 15 minutes.

The average time allowed for room turnaround is 10 minutes.

d. The optimum utilization of a dedicated, outpatient, general-purpose outpatient Procedure Room is 70% of full capacity. 70% x 250 days/year x 8 hours/day divided by 45 minutes = 1867 Cases per year.

The facility's projected utilization in year two of 12,981 cases demonstrates a need for 7 procedure rooms at the optimal standard (12,981/1,867= 7.0 rooms). The applicant is proposing only 6 rooms in this project.

Determination of Need

1. **Need.** The minimum numbers of 884 Cases per Operating Room and 1,867 Cases per Procedure Room are to be considered as baseline numbers for purposes of determining Need. An applicant should demonstrate the ability to perform a minimum of 884 Cases per Operating Room and/or 1,867 Cases per Procedure Room per year, except that an applicant may provide information on its projected case types and its assumptions of estimated average time and clean up and preparation time per Case if this information differs significantly from the above-stated assumptions. It is recognized that an ASTC may provide a variety of services/Cases and that as a result the estimated average time and clean up and preparation time for such services/Cases may not meet the minimum numbers set forth herein. It is also recognized that an applicant applying for an ASTC Operating Room(s) may apply for a Procedure Room, although the anticipated utilization of that Procedure Room may not meet the base guidelines contained here. Specific reasoning and explanation for the inclusion in a CON application of such a Procedure Room must be provided. An applicant that desires to limit its Cases to specific type or types should apply for a Specialty ASTC.

   In year two, the applicant projects 2,164 cases per room with 6 rooms.

2. **Need and Economic Efficiencies.** An applicant must estimate the projected surgical hours to be utilized per year for two years based on the types of surgeries to be performed, including the preparation time between surgeries. Detailed support for estimates must be provided.

   AmSurg has extensive experience operating and managing ASTCs and operates the nation's largest system of ASTCs. The average time for an endoscopy is 25 minutes and average turnaround/cleanup is 10 minutes in years one and two.

3. **Need; Economic Efficiencies; Access**. To determine current utilization and need, an applicant should take into account both the availability and utilization of either: all existing outpatient Operating Rooms and Procedure Rooms in a Service Area, including physician office based surgery rooms (when those data are officially reported and available) OR, all existing comparable outpatient Operating Rooms and Procedure Rooms based on the type of Cases to be performed. Additionally, applications should provide similar information on the availability of nearby out-of-state existing outpatient Operating Rooms and Procedure Rooms, if that data are available, and provide the source of that data. Unstaffed dedicated outpatient Operating Rooms and unstaffed dedicated outpatient Procedure Rooms are considered available for ambulatory surgery and are to be included in the inventory and in the measure of capacity.

The facilities utilization in 2014 averaged 1,865 cases per procedure room. Additionally, the applicant will increase utilization by room with the reducing total procedure rooms.

Service Area ASTCs 2014

Facility	# ORs Rooms	# Procedure Rooms	FY Cases	FY Cases per OR	FY Cases	FY Cases per Room
Children's West Surgery Center	3	0	4,569	1,523	0	0
Ft. Sanders West Surgery Center	4	0	2,003	501	0	0
Parkwest Surgery Center	5	1	3,704	741	1,639	1,639

The Endoscopy Center	0	8	0	0	9,953	1,244
The Endoscopy Center North	0	2	0	0	6,237	3,119
The Endoscopy Center West	0	2	0	0	4,929	2,465
Tennessee Endoscopy Center	0	3	0	0	7,081	2,360
Total	**12**	**16**	**10,276**	**856**	**29,839**	**1,865**

Source: *Joint Annual Report of Ambulatory Surgical Treatment Centers 2014 Final,* Tennessee Department of Health, Division of Policy, Planning, and Assessment-Office of Health Statistics

4. **Need and Economic Efficiencies**. An applicant must document the potential impact that the proposed new ASTC would have upon the existing service providers and their referral patterns. A CON application to establish an ASTC or to expand existing services of an ASTC should not be approved unless the existing ambulatory surgical services that provide comparable services regarding the types of Cases performed, if those services are known and relevant, within the applicant's proposed Service Area or within the applicant's facility are demonstrated to be currently utilized at 70% or above.

Not applicable. This project does not establish a facility; it only relocates an existing facility. It does not expand the facility in terms of surgical services.

5. Need and Economic Efficiencies. An application for a Specialty ASTC should present its projections for the total number of cases based on its own calculations for the projected length of time per type of case, and shall provide any local, regional, or national data in support of its methodology. An applicant for a Specialty ASTC should provide its own definitions of the surgeries and/or procedures that will be performed and whether the Surgical Cases will be performed in an Operating Room or a Procedure Room. An applicant for a Specialty ASTC must document the potential impact that the proposed new ASTC would have upon the existing service providers and their referral patterns. A CON proposal to establish a Specialty ASTC or to expand existing services of a Specialty ASTC shall not be approved unless the existing ambulatory surgical services that provide comparable services regarding the types of Cases performed within the applicant's proposed Service Area or within the applicant's facility are demonstrated to be currently Utilized at 70% or above. An applicant that is granted a CON for a Specialty ASTC shall have the specialty or limitation placed on the CON.

The applicant will perform only outpatient gastroenterology cases, and only in procedure rooms. The average time for an endoscopy is 25 minutes and average turnaround/cleanup is 10 minutes in years one and two.

Other Standards and Criteria

6. Access to ASTCs. The majority of the population in a Service Area should reside within 60 minutes average driving time to the facility.

The applicant complies with this criterion.

7. Access to ASTCs. An applicant should provide information regarding the relationship of an existing or proposed ASTC site to public transportation routes if that information is available.

The applicant complies with this criterion.

8. Access to ASTCs. An application to establish an ambulatory surgical treatment center or to expand existing services of an ambulatory surgical treatment center must project the origin of potential patients by percentage and county of residence and, if such data are readily available, by zip code, and must note where they are currently being served. Demographics of the Service Area should be included, including the anticipated provision of services to out-of-state patients, as well as the identity of other service providers both

in and out of state and the source of out-of-state data. Applicants shall document all other provider alternatives available in the Service Area. All assumptions, including the specific methodology by which utilization is projected, must be clearly stated.

The applicant is the only single specialty ASTC dedicated to endoscopy cases in the service area. In 2014, Digestive Disorders Endoscopy Center performed 1,166 cases per room.

The applicant's service area is Anderson, Blount, Jefferson, Hamblen, Knox, and Sevier counties.

The does not believe this project will have any significant negative impact on other facilities. There are seven ASTCs performing endoscopies in the service area. The utilization of these rooms in 2014 was 1,865 cases per rooms, of 89% of the State Health optimal standard for procedure rooms.

Service Area ASTCs 2014

Facility	# ORs Rooms	# Procedure Rooms	FY Cases	FY Cases per OR	FY Cases	FY Cases per Room
Children's West Surgery Center	3	0	4,569	1,523	0	0
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Total	**12**	**16**	**10,276**	**856**	**29,839**	**1,865**

Source: *Joint Annual Report of Ambulatory Surgical Treatment Centers 2014 Final,* Tennessee Department of Health, Division of Policy, Planning, and Assessment-Office of Health Statistics

9. Access and Economic Efficiencies. An application to establish an ambulatory surgical treatment center or to expand existing services of an ambulatory surgical treatment center must project patient utilization for each of the first eight quarters following completion of the project. All assumptions, including the specific methodology by which utilization is projected, must be clearly stated.

The year one and two utilization is projected to be and 12,852 and 12,981 cases, each year respectively.

The applicant projects in year one, Q1- 3,213 cases, Q2-3,213 cases, Q3- 3,213 cases and Q4-3,213 cases. In year two, the applicant projects Q1-3,245 cases, Q2-3,245 cases, Q3-3,245 cases and Q4- 3,246 cases.

10. Patient Safety and Quality of Care; Health Care Workforce.

a. An applicant should be or agree to become accredited by any accrediting organization approved by the Centers for Medicare and Medicaid Services, such as the Joint Commission, the Accreditation Association of Ambulatory Health Care, the American Association for Accreditation of Ambulatory Surgical Facilities, or other nationally recognized accrediting organization.

The applicant is already AAAHC accredited and will remain so.

b. An applicant should estimate the number of physicians by specialty that are expected to utilize the facility and the criteria to be used by the facility in extending surgical and anesthesia privileges to medical personnel. An applicant should provide documentation on the availability of appropriate and qualified staff that will provide ancillary support services, whether on- or off-site.

The medical staff consists of 12 Gastroenterologists. Their Board Certifications are provided in Attachment C-Need-1.A.3. The facility requires they be of appropriate anesthesiology coverage.

11. Access to ASTCs. In light of Rule 0720-11.01, this lists the factors concerning need on which an application may be evaluated, and Principle No. 2 in the State Health Plan, "Every citizen should have reasonable access to health care," the HSDA may decide to give special consideration to an applicant:

a. Who is offering the service in a medically underserved area as designated by the United States Health Resources and Services Administration.

The applicant's service area is Anderson, Blount, Jefferson, Hamblen, Knox, and Sevier counties. Parts of the service area are MUA. Those parts are identified in Attachment C-Need-1.A.

b. Who is a "safety net hospital" or a "children's hospital" as defined by the Bureau of TennCare Essential Access Hospital payment program;

Not applicable.

c. Who provides a written commitment of intention to contract with at least one TennCare MCO and, if providing adult services, to participate in the Medicare program; or

The applicant currently contracts with Medicare and three of the four TennCare MCOs and will continue to do so.

d. Who is proposing to use the ASTC for patients that typically require longer preparation and scanning times? The applicant shall provide in its application information supporting the additional time required per Case and the impact on the need standard.

This criterion is not applicable.